



THE JOURNAL
OF
MENTAL SCIENCE

(Published by Authority of the Medico-Psychological Association).

EDITED BY

D. HACK TUKE, M.D.,
GEO. H. SAVAGE, M.D.

“Nos vero intellectum longius a rebus non abstrahimus quam ut rerum imagines et
radii (ut in sensu fit) coire possint.”

FRANCIS BACON, *Proleg. Instaurat. Mag.*

VOL. XXXI.

25883
6/12/92

LONDON:
J. AND A. CHURCHILL,
NEW BURLINGTON STREET.

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"In adopting our title of the *Journal of Mental Science*, published by authority of the *Medico-Psychological Association*, we profess that we cultivate in our pages mental science of a particular kind, namely, such mental science as appertains to medical men who are engaged in the treatment of the insane. But it has been objected that the term mental science is inapplicable, and that the terms, mental physiology, or mental pathology, or psychology, or psychiatry (a term much affected by our German brethren), would have been more correct and appropriate; and that, moreover, we do not deal in mental science, which is properly the sphere of the aspiring metaphysical intellect. If mental science is strictly synonymous with metaphysics, these objections are certainly valid, for although we do not eschew metaphysical discussion, the aim of this Journal is certainly bent upon more attainable objects than the pursuit of those recondite inquiries which have occupied the most ambitious intellects from the time of Plato to the present, with so much labour and so little result. But while we admit that metaphysics may be called one department of mental science, we maintain that mental physiology and mental pathology are also mental science under a different aspect. While metaphysics may be called speculative mental science, mental physiology and pathology, with their vast range of inquiry into insanity, education, crime, and all things which tend to preserve mental health, or to produce mental disease, are not less questions of mental science in its practical, that is, in its sociological point of view. If it were not unjust to high mathematics to compare it in any way with abstruse metaphysics, it would illustrate our meaning to say that our practical mental science would fairly bear the same relation to the mental science of the metaphysicians as applied mathematics bears to the pure science. In both instances the aim of the pure science is the attainment of abstract truth; its utility, however, frequently going no further than to serve as a gymnasium for the intellect. In both instances the mixed science aims at, and, to a certain extent, attains immediate practical results of the greatest utility to the welfare of mankind; we therefore maintain that our Journal is not inaptly called the *Journal of Mental Science*, although the science may only attempt to deal with sociological and medical inquiries, relating either to the preservation of the health of the mind or to the amelioration or cure of its diseases; and although not soaring to the height of abstruse metaphysics, we only aim at such metaphysical knowledge as may be available to our purposes, as the mechanic uses the formularies of mathematics. This is our view of the kind of mental science which physicians engaged in the grave responsibility of caring for the mental health of their fellow men, may, in all modesty, pretend to cultivate; and while we cannot doubt that all additions to our certain knowledge in the speculative department of the science will be great gain, the necessities of duty and of danger must ever compel us to pursue that knowledge which is to be obtained in the practical departments of science, with the earnestness of real workmen. The captain of a ship would be none the worse for being well acquainted with the higher branches of astronomical science, but it is the practical part of that science as it is applicable to navigation which he is compelled to study."—J. C. Bucknill, M.D., F.R.S.

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No. 133. (New Series, No. 97.)

THE JOURNAL OF MENTAL SCIENCE, APRIL, 1885.

[Published by authority of the Medico-Psychological Association.]

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THE JOURNAL OF MENTAL SCIENCE, JANUARY, 1886.

[Published by authority of the Medico-Psychological Association.]

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THE JOURNAL OF MENTAL SCIENCE, JULY, 1885.

[Published by authority of the Medico-Psychological Association.]

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THE JOURNAL OF MENTAL SCIENCE, OCTOBER, 1885.

[Published by authority of the Medico-Psychological Association.]

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THE JOURNAL OF MENTAL SCIENCE.

[Published by Authority of the Medico-Psychological Association]

No. 133. NEW SERIES,
No. 97.

APRIL, 1885.

VOL. XXXI.

PART 1.—ORIGINAL ARTICLES.

On Insanity alternating with Spasmodic Asthma. By CONOLLY NORMAN, F.R.C.S.I., Resident Medical Superintendent, District Asylum, Monaghan.

At the general meeting of the British Medical Association, held at Belfast last autumn, I read a paper in the Psychological Section "On Insanity connected with Spasmodic Asthma." In that paper I described some cases as appearing "to point to an occasional connection between Insanity and Spasmodic Asthma, the nature of which seems to be—if the term may be allowed—metastatic, or alternating." I also stated that though I was aware Dr. Savage had had some cases of a similar nature, yet up to that date the subject had excited little attention, and no mention of it was to be found in English medical literature.

In the discussion that followed on my paper corroborative cases were mentioned. Some members, however, expressed the opinion that my observations merely indicated a masking of physical by mental symptoms, a view which appears to me quite untenable when one examines carefully the history and course of the cases.

I find that so long ago as 1872, Dr. Kelp, at that time Director of the Oldenburg Asylum at Wehnen, read an account of a case of Insanity with Asthma at a meeting of Alienists at Hanover (published in "Zeitschrift f. Psych.," xxix. 4). It is somewhat singular that Dr. Kelp's communication does not appear to have attracted much notice, and no similar cases were subsequently published in the specialist journals; particularly as the condition dealt with would not, according to my experience, seem rare.

Dr. Savage's observations have now been published in his "Clinical Manual." That work being in everyone's hands it is not necessary for me to refer to his cases except incidentally.

In Dr. Kelp's case the patient was an unmarried man, 28

years of age, in whose family insanity had existed on both sides. Some seven years before he came under observation he had suffered from an acute thoracic affection, the exact nature of which was not known. Subsequently he became liable to attacks of dyspnœa, sometimes acute, sometimes chronic, and often of great severity. He sought relief in subcutaneous injections of morphia, and also after a time in chloral taking. In both he exceeded largely. At length the asthmatic symptoms disappeared completely, and in their place came hallucinations of the senses, weakened will and intelligence, and finally maniacal excitement. On admission he was in wretched general health, and there were distinct signs of old organic lung mischief. Heart sounds clear. No dyspnœa. Extreme depression and anxiety amounting at times to desperation, accompanied by the delusion that he was being poisoned. Hallucinations of all the senses. During seven months no considerable alteration in mind appeared, though the physical condition improved greatly. On the contrary, while the patient became somewhat calmer, hallucinations continued, and various delusions of the fixed type appeared and developed. Suddenly his old asthmatic symptoms returned. At first there was excitement, and the patient threatened suicide if morphia were withheld; but as the asthma continued, and the attacks grew worse, the mind became gradually better. After about three months the hallucinations and delusions vanished altogether, the patient recognised that he had been insane, and recovery was rapid and satisfactory. On the other hand the patient now suffered habitually from asthma. In his remarks on this case Kelp draws special attention to the alternating (*vicarijrende*) relation between the mental affection and the asthmatic symptoms. He sees a pathological analogy between this case and those where irritative conditions of sensory nerves bring about the development of insanity, either during their continuance or after they have entirely ceased, and cites a case, reported by Griesinger, in which insanity appeared after cessation of neuralgia of the fifth.

I wrote to Dr. Kelp about this subject, and he was so kind as to reply in some detail to my enquiries. The above was the only case wherein spasmodic asthma and insanity appeared as alternating or vicarious (*vicarijrende*) phenomenon which he had observed during twenty years' work at the Oldenburg Asylum, and he had sought in vain for any mention of similar cases in the literature of the subject. He was also good enough to tell me that the patient above described remained mentally sound

after his discharge, and died in the course of some years from lung mischief.

In the discussion on Dr. Kelp's case, Dr. Lorent, of Bremen, described a similar one, in which a man who had long suffered from asthma with cough fell ill of melancholia at the same time that the chest troubles disappeared. Nine months later recovery from the mental affection took place, whereupon asthma and cough returned. A year afterwards the chest troubles vanished once more and the melancholia reappeared.

The influence that poisoning by morphia and chloral may have had in contributing to the production of insanity in Kelp's case has not escaped the notice of that observer. In the communication with which he courteously favoured me, he drew attention to the fact that the misuse of morphia and chloral in asthma may bring about insanity, or at least aid in its development. It is also to be noted that in addition to spasmodic asthma there was organic lung mischief in this patient.

With regard to the interesting question of metastasis in mental disease, insanity has been observed to alternate with gout (Berthier, Savage, and other authors). Insanity is said to have followed the healing of old ulcers and skin affections. A well-marked alternation has been observed between rheumatism and insanity (Griesinger, Clouston). Acute outbursts of insanity have been observed alternating with, and taking the place of, paroxysms of intermittent fever (Focke).

In reference to the association of mental aberration with lung disease, insanity has been observed with pneumonia, sometimes at the commencement of the disease, or at its height, or when the fever ceases, or even during convalescence (Griesinger, Jacobi, and others). Griesinger considered that these cases presented a special tendency to pass into chronic insanity. Wille and Schüle describe acute and chronic cases of insanity occurring with, or consecutively to, pleurisy. The intimate connection between insanity and phthisis is well known, and Clouston's special form of insanity with phthisis, characterized chiefly by monomania of suspicion and tendency to refuse food, has been well established by the experience of other observers.

It does not appear strange that insanity and asthma should be occasionally associated together when we consider either the pathology of asthma or its numerous nervous connections. It may be said that there are three main theories as to the essential nature of asthma. First, the doctrine, now an old one, that it is due to spasm of the bronchial muscles. The

most recent and able advocate of this view is Biermer. Secondly, that it is chiefly caused by tonic spasm of the diaphragm (Wintrich). Thirdly, the theory of Weber, to which the tracheoscopic experiments of Störck lend support, that asthma is due to a tumefaction of the bronchial mucous membrane, in consequence of dilatation of the blood-vessels through vasomotor nervous influence. It may perhaps be permitted to one to say that the recent experiments of Riegel go to prove that all three agencies are at work, though Riegel himself only admits that asthma is due to two—chiefly spasm of the diaphragm and intercostals, together with engorgement of the bronchial mucous membrane.

Whichever of these doctrines we adopt, the condition of asthma may be accounted for on the supposition of an alteration in the dynamic state of the respiratory centre in the medulla oblongata. It may be conjectured that this alteration may occasionally extend to the adjacent vasomotor centre, thereby affecting the supply of blood to the brain. Or, on the other hand, a wave of disturbance may pass down to the medulla, having originated in the higher centres, for we know the immense influence which the latter can at times exercise over those more directly controlling the respiratory and vasomotor functions. The phenomena of some cases of asthma (where, for example, a paroxysm is produced by emotion) themselves indicate this. In this connection it may not be uninteresting to point out that Christiani, and Martin and Booker claim to have discovered an additional respiration-regulating centre in the mid-brain of certain lower animals.

That asthma has many analogies with the diseases classed as nervous, and that it is often closely connected with them, has long been well known. It is not necessary to more than remind my readers that Trousseau, and, indeed, many others, have maintained that spasmodic asthma is hereditary, nor need I dwell upon the variety of causes which will produce an attack of asthma in the same or different subjects; this curious diversity being scarcely explicable except through the intervention of the nervous system. Many varieties of reflex asthma have been described (uterine, verminous, &c.), but probably the best instance of this form is offered in the case given by Hänisch of asthma caused by nasal polypus—disappearing when the polypus was removed and returning whenever the polypus grew again. Asthma has been stated to occur in consequence of retrocession of eruptions, particularly herpes (Waldenburg). Asthma has been connected by various

authors with rheumatism and gout, the many nervous connections of which diseases we need not stay to consider. Asthma has been found to follow lead-poisoning, and we know that this metal exercises its toxic effects chiefly upon the nervous system, sometimes producing insanity (Bartels and others). Cases are on record of asthma with angina and hemicrania (Eulenburg); asthma with hydrocephalus (Salter); asthma with hydrocephalus and convulsions (Graves); asthma alternating with epilepsy (Salter); and asthma alternating with angina, with gastralgia and with hemicrania (Anstie). I have myself seen a case, to be again referred to presently, in which asthmatic attacks and attacks of angina occurred in the same person, sometimes together, sometimes alternating, and this person suffered also from at least one attack of insanity; but the chest symptoms did not exhibit, as far as I could make out, any metastatic or alternating relation with the mental.

The following is a brief summary of all the cases which I have observed in which spasmodic asthma and insanity existed in the same individual:—

I.—Mrs. M. M., aged 45, farmer's wife, mother of several healthy children. No hereditary history of insanity or chest affections. She has always been of a rather excitable and nervously irritable disposition. Her health was very good till her twenty-fifth year, when she became liable to asthma, from which ailment she suffered for the following twenty years. From the description her relatives give I have no doubt the affection at this stage was true spasmodic asthma. There would appear to have been rather less bronchial catarrh than is usual. The attacks were very frequent, and often very severe and prolonged. They mostly began during the night time.

Three months before she came under observation her asthma ceased to show itself, apparently quite suddenly. At the same time she became odd in manner—silent, which was not natural to her, and seemingly pre-occupied. She grew restless, went about talking to herself, exhibited groundless anxiety over trifles, and performed small household duties over and over again because she thought they were not done rightly. Later on, when her husband and sons went out to attend to their farm work, she would follow them to see that they came back alive. Finally extreme restlessness set in and then refusal of food.

When admitted to the asylum she presented the typical symptoms of melancholia agitata. There was no persistent refusal of food, though she was always inclined for a time to refuse to do anything she was bid to do, saying "If I do so-and-so I shall die." She exhibited constant aimless restlessness, which sometimes became intense, continually endeavouring to escape through every door she saw open,

picking her clothes shred from shred, and often repeating monotonously for hours short phrases of sorrow or dread. A delusion that she was about to be burned was often expressed. Physically the chest was well shaped; there was no sign of emphysema, and the heart-sounds were clear.

The progress of the case it is not necessary to detail further than to say that after the insanity had lasted two and a half years the asthma returned, but without being followed by any amelioration of the mental symptoms, which undergo slight variations from time to time, but on the whole remain very much the same as when the patient was admitted. The variations in mental symptoms have no apparent connection with the asthmatic attacks. The latter are very frequent, and belong to the true spasmodic variety.

II.—G. M., a man of about fifty years of age, in a respectable official position, married, and having a number of children, all of whom are said to be healthy, has been under my care suffering from spasmodic asthma. Of his antecedent family history I can obtain little or no reliable information. His personal history is as follows:—He had been an intelligent man, of a cheerful, lively disposition, and had enjoyed excellent health, physical and mental, up to about seven years ago. He then became causelessly silent and morose, and gave rise among his friends to considerable anxiety by expressing unaccountable and irrational apprehensions that people were plotting against him and taking away his character; that he was being watched, and that his employer was harbouring suspicion of everything he did. These fears were utterly groundless, but they took such possession of him that he was incapacitated from work, and his friends were alarmed lest it should be necessary to put him under restraint. While affairs were in this state he for the first time became asthmatic, and immediately his beliefs as to plotting and persecution vanished. He resumed his business, and has held a position of trust ever since. He remains liable to frequent and severe attacks of spasmodic asthma. The paroxysms mostly begin in the middle of the night. I have not been able to detect any physical sign of heart disease. There is considerable emphysema. There is a tendency to pretty severe bronchial inflammation, especially after sharp or prolonged attacks of asthma. Mentally, he is intelligent and exhibits no trace of delusion or eccentricity, but he is now somewhat taciturn and rather depressed in manner. The weight of increasing years and constant physical suffering are quite enough to account for his present state of mind, in so far as it appears to differ from the status quo ante.

III.—J. W., male, 32 years of age, single, of peasant class, was admitted to the Castlebar Asylum on April 7, 1883. There was no hereditary history of neurotic or phthisical taint ascertainable. The patient is stated to have been of average intelligence and readiness to learn, and never to have exhibited any signs of mental aberration till the oncome of

the attack about to be described. He suffered from early childhood from spasmodic asthma. Some ten days before admission it was remarked that he was unusually silent and downcast in manner. For three or four days he had been without a paroxysm of asthma, a circumstance that he could not remember to have occurred before. His silence and gloominess became more remarkable, and finally, seven days before his admission, he confided to his brother that he was haunted by a constant "thought" of killing his mother. This "thought" was at first clearly of the nature of an "imperative conception" (*Zwangvorstellung*). It suggested itself continually to his mind, becoming constantly more and more vivid and associating itself with every other idea. He then became overpowered with a dread lest he should really carry out the horrible notion. He thought he felt an impulse to put in action the ever-present thought. He entreated his mother to avoid him, and begged to be sent to the asylum. His relatives, thoroughly alarmed, acceded.

On admission. General physical condition poor. Phthinodal build. No sign of emphysema. On the contrary, resonance was hardly satisfactory beneath either clavicle. Heart-sounds normal. There had been no dyspnoea for "ten days or more." After most minute and detailed examination of his mental state I thought there was some degree of depression in manner, &c., and that he hardly took a sufficiently intelligent interest in things around him. Otherwise I could detect no sign whatsoever of mental alienation, except the morbid conception and impulse that according to his own admission existed.

He said that the idea or impulse above described was constantly present in his mind, and kept him in an unhappy, restless, harassed state. He deplored its wickedness. He admitted its unreasonableness, but he was unable to exclude it from his thoughts, and the feeling that it was both wicked and unreasonable only increased his sufferings. He felt happier now that he was so placed that he could not do harm. He stated that he slept little. He was placed under close observation, but behaved with such order and calmness that he was permitted within a few days to work on the asylum farm. He was found to sleep well, and he admitted that he slept better since he resumed work. He did not in the least obtrude his unhappy condition on one's notice, and there was nothing in his manner or bearing in the smallest degree hysterical. The very frequent association of *Zwangvorstellungen* with sexual depravity was not overlooked, but nothing was ascertained to lead to the belief that there had been either sexual excess or irregularity.

On one occasion he expressed a hope that his asthma would return, saying he thought he never would be well till this would occur.

On the night of April 21, that is, just a fortnight after his admission to the asylum, he had an attack of asthma. Visited in the

morning about ten, he was found still suffering a good deal—not able to lie down, face very blue, small piping râles here and there over the chest. The expression of the patient's countenance was entirely changed. Of course there was the look of physical oppression, but the absence of the uneasy, timid expression he had before presented was most remarkable. He immediately said, "Thank God, I am better now. My mind is less unhappy." During the whole of this day he suffered off and on with his breathing, but he was quite cheerful and chatty in the intervals of comparative ease. His whole manner was changed, being bright and intelligent. On the following day he told me that he slept comfortably till morning, when he had a slight return of the asthma, and he said that he was "perfectly master of his own thoughts"—the imperative conception that had tormented him having ceased to recur since the first return of the asthma. He appeared to be completely restored to such health as he had enjoyed before the oncome of mental derangement. There was no recurrence of morbid impulse or idea, as far as could be made out, and I think the patient's statement in this respect was quite trustworthy. He might be fairly called a cheerful, active and intelligent man. The attacks of asthma recurred frequently, and were sometimes of considerable severity. A day rarely passed without some degree of asthmatic difficulty of breathing. He remained under my direct observation till July 7, 1883, when he was discharged, and I have heard nothing of him since.

IV.—P. M., male, aged about 20 years when admitted to the asylum. He is an illegitimate child, and nothing is known of his family history and little of his personal antecedents. He had been brought up in a workhouse. He was always looked upon as weak-minded. He had, however, been taught to read and write. He was said to have suffered habitually from shortness of breathing, sometimes aggravated to paroxysms of great severity.

When he came under observation, being then, as was stated, a few weeks insane, he was violently maniacal, very incoherent, very fierce, and excessively filthy in his habits. This condition lasted for a long time—fully a year—without any amelioration. Then followed a lengthened period of dulness, with gradual cessation of excitement. Physically he was in poor general condition on admission, deeply pitted with old marks of smallpox. The chest was barrel-shaped and unduly resonant. Heart-sounds clear. During the time that he was much excited he had several crops of large boils. About three years after he came under notice he had become perfectly calm, and at this period his dyspnoea returned. He remains for some years a chronic sufferer from spasmodic asthma. He is very weak-minded, but tractable. He seems to have reached a condition of mental equilibrium at a level considerably lower than that of the period before the acute attack of insanity. It is impossible to definitely date the attainment of this condition, but it corresponds pretty exactly to the time at which

his asthma recurred. No symptom of the latter affection was observed while the patient was maniacal, or during the subsequent prolonged period of partial torpor.

V.—Mrs. X. was a woman of bad family history. Married to a first cousin, a man of extreme eccentricity. At least one of her children died in infancy of convulsions, and one, who attained to maturity, suffered from infantile paralysis. Much domestic anxiety caused by the business incapacity of her husband. Mrs. X. was always a woman of a highly excitable disposition, garrulous to an extreme, very passionate and easily moved to emotion. At about thirty years of age she became liable to spasmodic asthma, from which she suffered very severely for the next ten years, when, after a period of more than usual trouble as to money affairs, &c., she became insane, her friends say, quite suddenly. She was not under my treatment, so that I am not in a position to say much as to her mental state, but she appears to have suffered from delusions of suspicion. She thought her husband wanted to poison her, and she made an attempt to kill him. After about six months' seclusion she made a good recovery. I knew her intimately both before and after this illness, the details of which she was not unwilling to speak of. She often mentioned to me as an odd circumstance that from the time her mind began to fail, from the time she first entertained suspicion of her husband, she had no trouble of breathing whatsoever, until her mind became clear again. This statement was confirmed fully both by her relations and by those who had been in immediate charge of her. Neither the patient nor her friends attributed her insanity to her chest affection, but were convinced it had arisen from constant worry and anxiety. While I knew the lady she remained a great sufferer from asthma, and had no recurrence of insanity. She left the country some years ago, and I have lost sight of her.

VI.—G. H., male, 30 years of age, farmer, married, was admitted to the Castlebar Asylum on the 14th January, 1883. History very imperfect; no neurotic taint discovered; a sister died of phthisis; mother was asthmatic. Patient suffered from asthma for many years. This affection is stated to have become less severe about two years before admission. From the same period, though they do not connect the two events, his relations date the commencement of his mental affection. He became odd in manner, negligent of his business, and fond of being alone. After about a year he became very much worse in mind, being taciturn, suspicious, and easily excited to passion. Gradually delusions appeared, chiefly that he was being poisoned, that people were plotting to kill him, and the like. He refused food at times. He had no attack of asthma nor any dyspnoea for nine months before his admission.

When admitted he was in somewhat feeble general health. The lungs showed no sign of emphysema or any other disease. A faint

murmur with the first sound was occasionally audible at the base of the heart, chiefly over the pulmonary valves. No symptom of heart disease. Kidneys healthy. He was full of delusions with reference to his food, and to the actions of all those about him, thinking that everything that was done had some relation to him. He seldom answered questions. Very obstinate and restive. Perpetually made desperate and violent attempts to escape, trying to throw himself out of every window, to bolt through every open door, &c. Restless. Bit his nails below the quick. Extremely violent when thwarted. For the first year or so that he was in the asylum there was no improvement at all. Since then there has been a gradual amelioration of mental state. The delusions seem to have lost their edge, and exist rather as an insane habit of mind than in their earlier active state. They are seldom referred to, and have no influence on conduct. The patient has become quite harmless and tractable. There is marked weakness of mind, and he exhibits many of the tricks of gesture, &c., so common among chronic demented. Till November, 1884, he exhibited no symptom whatsoever of asthmatic trouble. At that date he got a very severe attack of spasmodic asthma. Ever since he has had frequent attacks, and he suffers from a constant asthmatic dyspnœa. The chronic calm condition of partial dementia was well established before the return of the asthma, and there has been no further change in mind.

VII.—One other case of asthma with insanity I have observed which differed in some particulars from all those above mentioned. The patient, a man aged 41 years, exhibited the physical signs of a large fatty heart. He suffered from paroxysms of angina pectoris, which were generally accompanied by dyspnœa, more or less severe. He also had occasional attacks of spasmodic asthma, without the pain or other symptoms of angina. For many years he had been in feeble health. When he was under my care he was convalescent from an attack of what appeared to have been simple acute melancholia with tendency to suicide. The asthmatic and anginal attacks persisted throughout. There was a tendency to severe bronchitis.

All the foregoing cases except the last have one remarkable feature in common. They all show a marked alternation of mental and pulmonary symptoms. Thus in the first case we have chronic asthma vanishing when insanity comes on, and re-appearing when the mental trouble becomes chronic. In the second, asthma cuts short and takes the place of an attack of insanity. In the third, perhaps the most remarkable and interesting of the series, habitual asthma disappearing, its place is rapidly taken by insanity, which again disappears immediately on the return of the asthma. When the last change occurred the patient was under close observation in an asylum,

so that there can be no doubt as to the sequence of events. It would probably be carrying scepticism too far to say that the cure was due to the action of expectant attention in a patient already convalescent. In the fourth case, chronic asthma occurring in an imbecile ceases with an acute attack of insanity, and comes on again when the latter has passed off. In the fifth the same order of things is observed as in the third. In the sixth, chronic asthma lessens in severity and finally disappears with the oncome of insanity: when the mental defect becomes chronic with some degree of amelioration, asthma returns.

Analysing the mental symptoms in each case, it will be observed that the first and the seventh presented the character of acute melancholia, though the former has become chronic in its course. The fourth was a case of acute mania, occurring in a person of originally feeble mind, and followed by an increase of feebleness. The four other cases all exhibited the characteristics of chronic degenerative mental disease rather than of acute insanity, and this is the more remarkable as they were mostly acute in their course. The significance of delusions of persecution, tending to be organized, it is needless to point out, but it may be necessary to note that impulses and imperative conceptions such as those found in the third case are almost unknown as symptoms of an acute primary neurosis. Krafft-Ebing, who has given much attention to this subject, classes imperative conceptions among the signs of mental degeneration. They are found in persons exhausted by sexual excess, or burdened with the load of strong hereditary neurotic taint.*

The cases recounted by Dr. Savage and Dr. Kelp similarly bear the impress of a chronic incurable malady, though two out of four noted by the former observer recovered, as did the single case recorded by the latter.

A considerable similarity is to be seen between the mental symptoms ascribed by Dr. Savage to the form of insanity which alternates with asthma and those of the insanity of phthisis, which is also of the chronic degenerative type. The actual resemblance of symptoms is less marked in my cases.

* "Die Träger dieses peinlichen Krankheitszustands sind meist erblich belastete Individuen von neuropathischer Constitution, die besonders häufig in der speciellen Form einer hysterischen or hypochondrisen Neurose Auftritt."—"Lehrbuch der Psychiatrie," B. ii., s. 96. Similarly Schüle: "Stets ist eine neuropathische Disposition (Heredität, Uterinleiden, Onanie, vorausgegangener Typhus) mit noch anderen nervösen Störungen nachweisbar."—"Handbuch der Geisteskrankheiten," 2te. Aufl., s. 89.

In three of Dr. Savage's cases there was a history of phthisis in the family. In one a history also of insanity. In Dr. Kelp's case neurotic taint existed, and there appears to have been phthisical trouble. In one of my cases there was organic lung-delicacy that will probably end in phthisis. In only one was there any hereditary history of phthisis. Hereditary tendency to insanity existed in one case. In none of the others was any special hereditary taint discovered.

On Epileptic Violence. By M. G. ECHEVERRIA, M.D. Late Physician-in-Chief to the Hospital for Epileptics and Paralytics, and to the City Asylum for the Insane, New York, etc.

The important clinical researches on Epilepsy during the last decade have contributed to afford a sound criterium for a correct discernment of the curious physical phenomena connected with this dreadful neurosis, in cases where it becomes of great moment, for a legal decision, to establish the positive grounds for a just estimate of the sanity or insanity of a culpable act committed by an epileptic. To the important bearing of the matter to be here briefly discussed, we have been fully alive for many years past, laying upon it particular stress, in the light in which we present it, as our contributions on the subject testify. There are, however, noteworthy points related to epileptic violence which stand out in great clearness, but have not as yet received a proper recognition, as it is evident from the doubts raised by the writer of an editorial article in the "*Lancet*," August 9, 1884, on the case of Joseph James Donnelly, who was sentenced to death for the murder of his sister and for severely wounding his mother, in a paroxysm of what may have been epileptic furor, and who has been respited during her Majesty's pleasure :—

There are, nevertheless, remarks the "*Lancet*," features in the case of Donnelly that do not really lend themselves to the presumption of his insanity. For example, while it is true, as pointed out by Doctor Cullingworth, that the sister and mother attacked were not at the time so obnoxious to him as was his father, it cannot be forgotten that the sister had just refused to get him some water to drink, and, for the moment at least, she may therefore have been the object of his special animosity. It is necessary to bear in mind that in the most clearly marked cases of epileptic mania, there is generally an entire absence of motive or cause of quarrel ! (*sic* in original.) The maniac,

without preparation, instantly attacks the nearest person, though he be his dearest friend.

The judicious questioning of received opinions is the very source of scientific progress, but the assertions just quoted, and the strong categorical way in which they set forth the characteristic peculiarities of epileptic violence, are not justified by experience. The following examples from our own records, with those we present from different classical authors, grouped together, demonstrate the unreliable foundation of the preceding absolute principles, based, as we do not hesitate to declare, on evidence that frequently speaks in an opposite sense.

The history of Donnelly's case, certainly, must have satisfied the authorities of their duty of preventing the execution of a capital sentence. Be this as it may, the above-noticed remarks stand by themselves, not as representing an individual theory, but as an acknowledged medico-legal principle. We agree with its propounder that, all medical evidence being an expression of opinion, it is manifestly of the highest moment to determine among ourselves on what grounds and in what way our opinions are to be formed. For this reason, let us at once examine, guided by the positive data at our command, whether :

1st.—*The mental derangement attending the epileptic attacks precludes the existence of animosity in any post-epileptic act of violence.*

And, 2nd.—*If it is true that in the most clearly-marked cases of epileptic mania, there is generally an entire absence of motive or cause of quarrel.*

The first point finds itself intimately connected with that of premeditation, though we by no means suppose that violent ill-will or hatred and deliberation are equivalent feelings, notwithstanding their parallel occurrence and the readiness with which one is apt to merge into the other. It is so rare not to observe them jointly that we will consider animosity and premeditation as they may appear in mutual relation to acts of violence executed during the automatism of epilepsy. And we, intently, do not say of epileptic mania, because our standard authorities on psychological medicine have long since proclaimed that deliberation is not incompatible with insanity. Epilepsy is not a form of mental disease in the ordinary sense applied to the word mental, but as we were one of the first to establish it, in a communication read before the Association of Medical Superintendents of American Institutions for the

Insane, in May, 1873,—it is a neurosis which does not exist in any of its forms without causing a more or less complete unconsciousness, an *essential element* in its pathogeny, that entails a loss of will and of emotional control, with defective judgment; effects which, though not always striking, are nevertheless potent factors of mental disorder, obviously manifest in epileptic mania and the larvated or mental attacks, as much as in the post-epileptic psychical stage that may last from a transient moment to several hours, or even days, and throughout which stage the epileptic acts automatically, in a seemingly rational manner, his actions varying from a simple, awkward, purposeless gesture to any kind of more elaborate designed movements.

The synthetic analysis of the psychical aspects of epilepsy plainly evinces that even when the highest nervous arrangements do not lose entirely their control over the lower ones, *i.e.*, when the epileptic does not run at the end of his fit into a frantic, furious mania, but acts unconsciously in a quiet, automatic manner, without the least judgment on the moral character of his conduct, he is then in a diametrically opposite condition to that of a sane man, for his actions are the outcome of a disease affecting his nervous centres, and so rendering him incapable of controlling his own conduct, or of knowing that the act he has perpetrated is wrong; and consequently in one word, he is irresponsible therefor. These are not abstract speculations, but legitimate deductions from well-defined cases, which we pass on to notice, beginning with a typical instance of how disappointment and irritation, experienced before the epileptic fit, did operate afterwards in a manner that vividly brought back in a delusional way the primitive ill-humour and anger to determine a violent aggressive act, blindly executed during the unconscious post-epileptic automatism—when the patient's voluntary activity was in abeyance, and the mind, without any spontaneity, remained open to all sorts of psycho-sensorial and psycho-motor phenomena.

A young lady, subject to fits of *petit mal* and *grand mal*, followed by temporary mental disturbance, having remained for several weeks free from either kind of fits, was seized with four successive paroxysms of *grand mal* within two hours, as she was about preparing herself to go to a theatrical *matinée*. She raved, as usual, after the fits, and had to be taken to bed. In the intervals of the attacks she insisted upon being dressed to go out, without making, however, in her exasperations, any attempt to get up, and her mother endeavoured to

quiet her by kind promises and caresses. She became apparently calm, and asked for a glass of water, which was handed to her, and on holding it she said, "Darling mother, let us cease fighting; come, do sit by me in this chair;" but, as the unsuspecting mother sat down to gratify her daughter's wish, she gave her mother a violent blow with the glass on the forehead, wounding her severely, while exclaiming—"Now, now, I am satisfied; don't let me dress up and go to the theatre." Thereupon the girl continued in a state of mental excitement, which lasted until next day; but she did not preserve the slightest recollection of the above circumstance; its occurrence was even concealed from her, as she became deeply affected on noticing her mother's wound, and being told that she had inflicted it when labouring under one of her fits.

Nothing more strikingly shows the unconscious reproduction of the special animosity of the epileptic during the post-epileptic automatism than this example.

A female patient at the Hospital, subject to epileptic mania after her fits of *grand mal*, in order to have her diet changed, took to simulate her convulsive attacks during the House Physician's absence from the wards. Her imposture was soon detected, and from that moment she manifested an unconcealed animosity to the nurse. Her fits had been always followed by stupidity with silly laughing, lasting several hours, accompanied by homicidal impulses against any of the bystanders, up to the time of the discovery of her imposture, when it was noticed that she began to display her maniacal aggression chiefly against the nurse who reported her simulated fits, watching for every opportunity to follow her into isolated places to assault her, and would then become so furious that she had to be shut in a separate room until the maniacal attacks ended by a stertorous heavy sleep of several hours.

How far a smart feeling of resentment may become the immediate determining cause to develop not only the fit, but its evil moral consequences, is plainly illustrated in this case:—

A boy, sixteen years old, had nocturnal fits, induced, as his father suspected, by masturbation, though no proof existed to that effect. A physician had asserted that onanism always caused this kind of epilepsy; and on this assurance the father endeavoured to obtain a confession from the boy, who firmly denied the accusation, though he acknowledged that he had heard other boys at school speak about such a bad habit. This examination, made one Sunday morning, wounded the boy's feelings so deeply that he did not breakfast, but remaining in his room taciturn and sullen, had the first diurnal paroxysm. This sad result carried to the father's mind the conviction that he had detected the real cause of the disease. From that day, whenever the boy was questioned on this point by his father or by

any physician, as we had occasion to witness, his resentment became so extreme that he refused talking any more, and was seized, soon after, by an epileptic fit. He entreated his father not to hurt him any more with unfounded suspicions and investigations of this character, to which the father was deaf, until one morning, directly after an examination accompanied with severe reproaches, the boy was seized with a convulsive fit, and on recovering from it he shut himself in his room and hung himself, having several times before threatened to commit suicide if he continued to be unjustly thought guilty of a wicked habit he had never practised. No other cause, except the irritating indiscreet questions just noticed, ever induced a diurnal attack in this case, which had such a melancholy end a few months after we reported it, for the first time, in 1873, to show how the unnatural reflex excitability of the nervous centres in epilepsy may determine the extreme susceptibility which culminates in the onset of an epileptic paroxysm with all its singular psychical manifestations.

In the case of David Montgomery, a young epileptic, in the city of Rochester, New York, sentenced to death for killing his wife, a vile prostitute, on the morning of the 13th of November, 1870, jealousy was the feeling that prompted the crime, while he laboured under the influence of the post-epileptic automatism induced by a nocturnal fit, which had been preceded by several others during the previous days. Hereditary predisposition to insanity existed, in the highest degree, in David Montgomery's family. Notwithstanding the report of the Commissioners appointed by the Court to inquire into the mental condition of David Montgomery, declaring that he was tainted with a strong tendency to insanity, and that he had on different occasions exhibited epileptic attacks, chiefly of *petit mal*, followed by maniacal excitement with tendency to violence, and that by his demented looks he further bore evidence of a permanent epileptic condition, Montgomery was tried to gratify public clamour, and the jury found him guilty of murder in the first degree upon the groundless scientific assumption of the physician-witnesses called to prove his sanity by premeditation, among other evidences, for Montgomery said when arrested, while still unconscious, "that he waited five minutes to kill his wife because his temper got the upper hand of him." We were requested to examine into the mental condition of Montgomery while he was waiting for the execution of his sentence in the jail in Rochester, and we found plain evidence of his being then demented and actually suffering from long-standing nocturnal fits and *petit mal*. These facts were duly exposed to the Governor of the State, who appointed a Lunacy Commission, and upon their report corroborating our declaration, Montgomery was sent to the State Asylum for Insane Criminals at Auburn, thus narrowly escaping to forfeit his life, thanks to the earnest exertions of his learned and distinguished attorney, General H. Martindale.

We summarily notice this case because it exemplifies the

feeling of jealousy—and no feeling can arouse greater delusions than jealousy, nor could any brain be more susceptible to its evil influence than that of an epileptic—the influence still persisting during the unconscious post-epileptic stage, when the faculties of the highest perceptive centres become obliterated by the explosion of the fit, and determining in an automatic manner the purposive execution of elaborate acts related to the permanence of the vivid, acute impression in the morbid brain. The irresponsible nature of this we fully demonstrated in the medico-legal examination we made of the certified copy of the physicians' testimony and other evidence connected with the trial of David Montgomery, to which the reader is referred for the full history of this most interesting case.*

When studying these subjective sensational phenomena during the psychical manifestations that may attend nocturnal epilepsy we illustrated them with the example of a girl who, immediately after being seized with a fit while preparing for herself a cup of tea, took a small kettle of boiling water and automatically poured the water, not into the cup, but over her fore-arm and leg, burning herself severely. There is no difference between the thought and any emotion or feeling of animosity that might take hold of the mind before the onset of the attack, and the same idea, or feeling, vividly renewed, with blind persistency, during the period of unconsciousness or automatism coincident with, or rather constituting of, the fit, when not prolonging it. Hughlings Jackson has particularly noticed this peculiarity connected with the post-epileptic automatism.†

A female at Broadmoor, tried for feloniously wounding, had for several years been subject to violent and slight fits. "The circumstances of her act of wounding were referable to one of the more violent attacks, as reports Dr. Orange. She rose up from her chair one morning with her baby in her arms and went to cut some bread for the older child. Having got the knife in her hand for this purpose, she had an epileptic seizure, and during the unconsciousness she cut her infant's hand clean off, and was found insensible by the neighbours. She had no recollection of the circumstances after getting possession of the knife. On two occasions, when in these attacks, she had fallen into the fire, and in one she had cut her own thumb."‡

* "Criminal Responsibility of Epileptics, as Illustrated by the Case of David Montgomery."—"American Journal of Insanity," Vol. xxix, January, 1873, p. 342 *et seq.*

† "West Riding Medical Reports," 1875, p. 118.

‡ "Broadmoor Lunatic Asylum Annual Reports," 1876, p. 53.

In this latter instance, and in that of the girl who poured on herself the boiling water, it is the prior thought which occupied the mind at the moment of the explosion, or onset of the fit, and which persists to be unconsciously carried out during it, or during the post-epileptic automatic stage, in a more or less apparently rational manner. But there is still another class of cases in which we may equally observe any idea that may have possessed the patient's mind, or even a mental obsession of no ill-character, but capable of originating criminal acts of violence, suggested by the said obsession, though executed in an absurd, incongruous manner.

We have reported before the case of a lady subject to cerebral epilepsy, who, in one of her fits, entered the room of her infant daughter, and, passing the fingers of her right hand into the child's throat, would have suffocated her had not the nurse come to her rescue. The little girl was paraplegic, and unable to articulate a word. Electricity had been resorted to to arrest the wasting of the limbs, and so strongly possessed became the mother that it was going to cure and to make the child speak that she wanted to have the electrical applications repeated several times every day. When stopped by the nurse the mother pretended that she was transmitting her electricity into the girl's throat to make her speak and cure her paralysis, and became very mad and furious on being removed from her daughter's room.

Subsequently, this lady, during her mental fits, would ask for the electric battery, and would want to apply it to the child, incessantly returning to this besieging idea in proof of how coherently the mental phenomena develop themselves in the evolution of the epileptic paroxysm, notwithstanding the abruptness of their display. The *epileptic echo*, which we have described as commonly conspicuous in epileptic insanity, and as striking also in the writings of the epileptic insane, certainly proceeds from the peculiar state of the brain we are now considering, since the *echo* consists in the repetition of the same phrase present in the patient's mind, or of the words suggested to him, due to an unconscious cerebral automatism. The phenomenon also takes place at the onset of the attack, as in the remarkable case of the printer observed by Dr. B. D. Eastman, Superintendent of the Worcester Lunatic Hospital.* This patient frequently had a fit while composing, which resulted in making *pie* of what he had in his stick. The proof published by Dr. Eastman is extremely interesting, for it shows the time that elapsed and the number of co-ordinate

* "American Journal of Insanity," October, 1873, p. 301.

movements that were executed automatically before the patient became insensible, and last, though not least, the amount of deliberation that was necessarily required to execute the whole setting of the sentence preserved in the proof, which demonstrates beyond doubt how unwarranted it is to hold that the suddenness of the epileptic explosion renders impossible deliberation in any of the acts coincident therewith.

We would add that the mental obsession, or overwhelming idea, whether delusional or not, gives rise to hidden perverted feelings that may brood in the epileptic's mind until, by some external incitation, they are excited into mischief, as it is clearly brought out in this example of extreme medico-legal interest :—

A young man from Saratoga, with antecedents of insanity in his paternal family, and subject to fits of *petit mal* and *grand mal*, mostly nocturnal, showed a deep affection for his mother, who was the victim of the most cruel treatment on the part of the boy's father, a wretched dipsomaniac living separate from his wife. One day, during one of the unexpected dangerous visits of the father, the boy witnessed the brutal blows he struck, leaving extensive bruises on the chest of his defenceless mother. From that occasion not only did the son keenly experience a bitter resentment against his unnatural father, but it was besides observed, on different times, that his presence would at once induce a falling fit on the boy. This latter, on the eve of going abroad with one of his uncles, and unwilling to do it without securing a solemn promise that his forsaken mother would not be ill-treated in future by his father, came over to New York to have an interview with him to that effect. Fearing, however, the father's passion, and knowing that he was in the habit of going about always armed, the boy brought with him a revolver and went to his father's lodgings, during the evening, immediately after his arrival at New York. Not finding the father at home, he left him the name of the hotel where he put up, with a written request to visit him the next morning, which was promptly complied with by the father. Their interview, as related to us by the son himself when we examined him at the Tombs Prison a few days after the dreadful tragedy, was as follows, beginning by the circumstances preceding it the night previous :—

The boy, very fatigued from the railroad journey to New York, went early to bed, with a severe headache, and feeling very uneasy and agitated about his mother's fate. He distinctly remembered undressing himself to go to bed, and that long after, about three o'clock in the morning, he awoke and very much wondered at finding himself lying across the bed, with his boots, clothes, overcoat, and hat on, but unable to account for it in any way; then, undressing himself a second time, he soon went to sleep soundly, until aroused, about seven o'clock in the morning, by the hotel servant to

deliver him a message from his father who wished to see him. The son hurriedly dressed himself; sent word down for his father to come up, and waited, with the revolver in his trousers' pocket, ready to defend himself against any assault from his father. All that the boy recollected on seeing him enter the room was, that he came in with the right hand placed in the chest pocket of his coat, but of the subsequent events he had a very vague recollection. He fired five successive shots at his father, "with no will to stop his hand," which he felt descending "in jerks," at every shot. On running bewildered out of the room, with the revolver in his hand, he beheld, coming out from the room adjoining his, "a tall old man, with a long gray beard, who asked him: 'did the cap snap?'" and he returned to himself, choked by a feeling that stopped his breath, as he descended in great haste the stairs of the hotel to direct the clerk to telegraph to his mother that he had killed his father.

At the coroner's inquest, a letter written by the boy after his arrest was read, containing a declaration that he had killed his father in self-defence—a plea which was interposed before we discovered, upon medical examination, that the boy was subject to nocturnal epilepsy and to fits of *petit mal*, attended with post-paroxysmal unconscious attacks, as also the readiness of the convulsive fits to be induced by the father's presence, in addition to the facts already noticed, which were altogether incompatible with the declaration in the letter above alluded to, that the boy, as he informed us, wrote on his lawyer's dictation for the purpose of his defence, but, in reality, without any distinct recollection of what occurred to him, and chiefly basing his description of the catastrophe on what he heard about its details narrated immediately upon its occurrence, and at the coroner's inquest. The only witnesses of the terrible drama were the two who took part in it; one had his lips sealed by death, the other was the unconscious epileptic, whose recital, in reference to his feelings and the particulars of the event, so far as he was concerned, we have faithfully reproduced from a memorandum taken at the time of its sad occurrence in May, 1873.

These details bear the characteristic mark of the epileptic malady, too nicely delineated to have been feigned by the boy, who never suspected, any more than his desolate mother, his nocturnal attacks, nor the real significance of his strangeness and automatic conduct during the frequent fits of *petit mal*. I am not leaving our subject and straying into irrelevant speculations; for the interest of the boy's unpremeditated natural account of his conduct and feelings lies in the fact that it is applicable, with the same force, to the replies we usually hear from epileptics themselves, about the criminal or extravagant acts of which they are perpetrators, without the least judgment or knowledge as to their occurrence and

character, until they are rendered cognizant of their inevitable explosion by the remarks of the bystanders, which they repeat as their own, and which causes the hasty though natural conclusion that epileptics are not the irresponsible unconscious offenders which, on the contrary, they truly are when acting under the influence of their fit. It is, finally, evident that in this most lamentable case there was, firstly: a fit in the middle of the night, that originated the automatic exertion required to put the clothes, boots, and hat on, with set purpose to go out, before the boy dropped down across the bed at the end of the fit—thus acting under the prepotent thought of the interview at hand with his father, of so great consequence to the welfare of the distressed mother, and which was the paramount idea of all the conceptions of his unstable, weary brain, until the very last moment he ceased to be awake after he retired that night, very exhausted, with a severe headache. And, secondly, on awakening out of sleep that ill-fated morning, he beholds his father, and is seized by a mental instead of a falling fit as it had happened before, but this time with greater readiness to such a discharge, as the instability of the nervous centres was greater after the night's rest, and, furthermore, because the result of the strife of the piercing emotions and ideas which disturbed his cerebral activity had to culminate into the explosion of the logical automatic acts sprung from the resentment and fear of the boy against his father, it being, in the last place, a convincing proof of the irresponsibility of the blind actor in this revolting drama, the delusional presence of "the tall old man, with a long gray beard, who asked, did the cap snap?" as he came out from the room adjoining that of the tragedy, where no such imaginary person was lodged, neither was at the time anybody standing outside of the room to witness, at the closure of the fit, the bewilderment of the boy on running down stairs. So much for what seems to us to be the medico-legal meaning of this extraordinary case.

We could keep on referring to instances from our own practice in which a pre-existing ill-feeling prompted the unconscious act of epileptic violence, to convince the reader that it commonly happens so, notwithstanding the prevailing contrary belief; but we will let Delasiauve speak, there being no higher authority on the subject. An epileptic, after murdering his mother, was acquitted by the Court, and committed to Bicêtre. "There was," says Delasiauve, "nothing unnatural in raising objections in this case, namely, that the murder had been perpetrated under a dominant jealous feeling, and even with

an apparent motive, and that therefore it was fair to infer that, independently of the morbid excitement, it might have been prompted by a natural passion and become thereby punishable. This consideration, notwithstanding its weight, is far from carrying a decisive value. The instinctive perversions, consecutive to the epileptic fits, do not, as we have already seen, necessarily deprive the overt acts of epileptics of the marks of a voluntary determination. These patients are controlled, in the midst of their bewilderment, by an appreciable motive, which has for them a reality; but we should ask ourselves if in a state of sanity such a motive would arise, and, above all, if it would be predominant enough to upset the reason. Thus, the motive and premeditation which seem, under such circumstances, to have dictated the criminal act are by themselves insufficient to establish peremptorily the integrity of free-will, and consequently the proof of guilt.”*

These teachings, which completely contradict the extreme views set forth by the “*Lancet*,” were published about thirty years ago, and the long test of accuracy they have borne supports their truth. The facts already advanced are equally applicable to manifest how absolute and contrary to sound experience it is to assert, that: *in the most clearly marked cases of epileptic mania there is generally an entire absence of motive, or cause of quarrel*. We do not, indeed, put the case more strongly than strict truth warrants, if we declare that proofs in contradiction of these words are of daily occurrence, and fall under our hand at every page of the classical works on epilepsy. Not to appear too egotistic in this affirmation we forbear to bring forward any of our own examples, but cite well-known standard cases, which fully attest the obvious correctness of the principles we sustain. The two following instances are recorded by Devergie, who obtained them from Moreau de Tours.†

In 1841 Moreau de Tours had under his care at Bicêtre a young man from twenty-five to twenty-six, who had been condemned to death for murder, but whose sentence had been commuted to twenty years’ imprisonment. He was epileptic from infancy, and had received an accomplished education. He came to Paris with a young woman whom he expected to marry, and whom he loved dearly, but becoming jealous of her harmless coquetry, quarrels arose between the lovers. One evening, after a long promenade, X —, who for two days had been feeling unwell and giddy, came into the hotel and

* “*Traité de l’Épilepsie*,” Paris, 1854, p. 486.

† “*Bulletin de l’Académie de Médecine*,” Vol. xxvi, 1861, p. 436.

found his mistress sound asleep. Suddenly, he thought how unfortunate he would be if this young girl should prove false to him, and taking a pistol killed her. He immediately fell in an epileptic paroxysm, and was found in its struggles by the persons who hastened to the room.

A young man, aged 22, had suffered for five years from attacks called by the physician epileptic. "I am unwell," said he to Moreau de Tours, "every five or six weeks, having sometimes several attacks in one day. I have never noticed that this malady impaired my health until I was seized, a month ago, with fears of becoming insane, on the following account: I had a trifling disagreement with one of my friends, and two days after, having awoke all confused, the idea of this quarrel returned to my mind, and its recollection excited me to such an extreme that I conceived a feeling of hatred and revenge. Thereupon I rushed for a dagger, put it in my pocket, and hastened to my friend's lodgings with the design of murdering him. Fortunately, I had scarcely pulled the door bell when I dropped down in one of the fiercest paroxysms I ever had, my friend being the very first to come to my assistance."

Devergie concludes from these two remarkable examples that it is never during these seizures, but in their intervals, that criminal ideas are conceived by epileptics, and always in cases of confirmed epilepsy. Most assuredly, it is in genuine epilepsy that these psychological phenomena generally spring up; but the forcible illustrations cited by Devergie obviously demonstrate that the mental disorder, the irresistible impulse, may also be the immediate precursor of the epileptic seizure, forming its initial part. These examples exhibit the excessive irritability that foretells the paroxysm, and in no less significant manner corroborate what we have stated in regard to the perverted feelings that may precede and originate the fit, as much as the automatic misdeeds that may be its sequel; and last, though not least, that *there is not*, generally, an entire absence of motive or cause of quarrel in cases of epileptic mania.

Boileau de Castelnau reports a case worthy of being kept in mind whenever we are called upon to determine the limits of the responsibility of epileptics.*

John Paul J—, and Charles F—, both convicts in the Central Prison of Nîmes, had for a long time lived on bad terms with each other. On several occasions, and notably the 23rd or 24th of June, 1850, they were engaged in a passionate quarrel, during which

* "De l'Épilepsie dans ses Rapports avec l'Aliénation Mentale." Paris, 1852, p. 36.

John Paul addressed bitter and even injurious reproaches to Charles ; but, up to that time, they had not gone beyond a mutual exchange of words, more or less foul or insulting. The 29th of June, during the forenoon, a new quarrel on some insignificant subject broke out between the two convicts, *after which Charles was seized with an epileptic fit*, to which he was subject. During the fit Charles, seeing John Paul laugh, thought that he made a jest of his disease, and the belief tended not only to exacerbate the irritation left on his mind by the previous quarrels, but also to fill up the measure of his resentment. Thinking that the knife he possessed was not suitable to carry out the plans of revenge he contemplated, he exchanged it for another belonging to an Arab, who was also a prisoner. Shortly after this exchange the accused was seen twice sharpening the blade of his knife with the file he had borrowed from another Arab. It was then about three o'clock in the afternoon. Towards five or half-past five o'clock, John Paul saw the accused advancing towards him, and noticed that he kept his hand in his bosom, where he seemed to handle some object. Charles, on coming up to him, asked why he made a jest of his disease, and as John Paul returned a negative reply he proposed to him to fight. John Paul refused doing so, saying that he did not want to fight a man like him, adding, *that he excused him on account of his disease*. After these words, John Paul was about turning to go away when Charles suddenly rushed upon him, and drawing the knife from his bosom, rapidly inflicted *six stabs* on him. The most dangerous one was inflicted in the region of the heart ; the mammary artery having been wounded, the first diagnosis of the physician was that the wound would probably prove fatal, a prediction which was not, however, realized.

Boileau de Castelnau thus concludes his analysis of the case : " From the facts reported, Charles exhibited the characteristics of a derangement of the intellectual and affective faculties, induced by epilepsy, the attacks of which were frequent and of long standing. In one word, one cannot avoid this dilemma: either Charles had been impressed in an unnaturally morbid manner by the insults of his antagonist, insults which induced an epileptic fit, during which he was again no less unnaturally influenced by the laugh of the same antagonist, both circumstances driving him to a wicked vengeance and making him (Charles) act the part of a madman ; or again, Charles was impressed normally, but the consequence of his feelings were the acts of an insane man—*ceteris consentibus*, the loss of moral liberty, is incontestable. He had no motive to kill John and to slay him by such a number of stabs." The Court, on the demand of the defence, and the extenuating circumstances admitted by the jury,

lessened by two degrees the sentence, and Charles was condemned to six years' imprisonment. Boileau de Castelnau remarks that the conviction was obtained upon subsidiary circumstances connected with Charles' antecedents, it being manifest that the Court and jury were convinced, if not of the moral irresponsibility, at least of the want of control of his free will at the moment Charles perpetrated the crime. Strange conviction, for it acknowledges free will, to admit in the next breath the incapacity to control it, which rendered the man, in our opinion, entirely irresponsible, while it is also fair to presume that the culpable antecedents, which so much weighed to condemn Charles, were, in all probability, of an epileptic character, not ascertained by the Court.

We could not overlook the example cited by Dejœghère, in which the motive and the premeditation are fitly set forth, in a case that, on another hand, remains as a painful record of the punishment of a furious madman, not only unjust but unmerciful in its infliction :—

Rœgiers, aged 30, of strong constitution, was the son of healthy parents. When seven years old he was seized, upon a sudden fright, with an epileptic fit, soon followed by several others, chiefly nocturnal, increasing every time in intensity and duration, until lastly degenerating into a true rage. Rœgiers had a fight with a man named B—. Judged by the Court of Courtrai he was condemned to a few months' imprisonment. Rœgiers protested his innocence as to the charge brought against him. Furthermore, on leaving the Court he shook hands with B—, assuring him that he entertained no grudge against him, since he could not be held accountable for the wrong decision of the Court. However, it is this very man B— whom he after intends to kill, and to this effect Rœgiers was seen on the day of the murder steadily sharpening his knife for several hours on a grindstone, and repeating incessantly, "I shall know how to have you." He then goes out, in broad daylight, holding his knife, runs to B—, who lives in a very populous quarter, and boldly enters his house. But B—, on beholding Rœgiers coming with a knife, escapes through a back door. Rœgiers chases him, stabs B—'s sister, who endeavoured to defend him, and, finally, overtakes him and rushes upon his victim like a tiger. He inflicts upon him a deep wound in the neck, and plunges his nails in it to tear it asunder. A great crowd hastened to the spot, but the most daring were afraid of going to the rescue of the unfortunate B—. It was not until Rœgiers fell down that they took hold of him, and bound him with cords to a wheelbarrow. To every question put to any detail concerning his horrible crime, Rœgiers gave always this answer, "Since you make me aware of it, sir, I must needs believe it, but I completely ignore it."

The physician who examined on the mental condition of Rœgiers declared that he enjoyed full possession of his reason. Rœgiers was condemned to death, but the sentence was commuted to penal servitude for life, and the exposing for one hour. While suffering this last punishment he was seized with such violent convulsions that the executioner was obliged to place him in a chair, where he had the greatest difficulty to secure him.*

This determination beyond recall of the Court of Courtrai to carry out its sentence to the end, has a fitting parallel in Massachusetts.

The case happened in Boston, the Metropolis of New England, about fifteen years ago, and the victim of such cold execution of the law was again a wretched young epileptic, subject to diurnal and nocturnal fits, during which latter he would go up the roof of his house, dance in the most dangerous positions and accomplish unconsciously such other no less risky feats, which caused his neighbours to call them "dare-devilment." One evening this lad, under the influence of a fit, ran after his sweetheart into the street and took her life with a bread-knife he carried home, and of which crime he always protested to have no recollection whatever. Dr. Clement A. Walker, Superintendent of the Lunatic Hospital, Boston, endeavoured, unsuccessfully, to satisfy the jury that the boy was an epileptic, and that the homicidal act of violence had been the outcome of epileptic insanity. Consequently, he was convicted of manslaughter and sentenced to prison; but while the Judge was uttering the sentence, he fell into a violent fit, so violent that several officers—and he was a lad not much over fourteen—failed to control him. A physician was sent for, who etherized him, and he was taken back to jail. This physician testified that he thought the fit was feigned, and did not see any good evidence why it was not. About one week after the prisoner was called for sentence again, when he was brought in by one door, walked through the Court, and taken out by another door. It was ordered by the Court that the prisoner should be sentenced while thus walking through, lest he might be seized with another fit, which exploded twenty-four hours after confinement in prison.

In this singular case it became a question whether the execution of the law should be carried out in spite of everything, cheating as it were the epileptic malady from its attacks by the strategy of walking the boy across the Court while sentence was pronounced, in utter disregard of the statutory provision by which the prisoner must stand before the judge and jury to hear his sentence, as well as of every humane

* "*Annales de Médecine*," Belges, 1843. Quoted in "*La Folie Devant les Tribunaux*," par Legrand du Saulle. Paris, 1864, p. 422.

sentiment of commiseration to which the violent convulsions experienced by the boy in Court so strongly appealed, and which the Judge did not believe to have been simulated, as was demonstrated by the unprecedented and illegal proceeding he authorized in order to prevent the recurrence of a fit.

Reverting to our inquiry—what are the facts, and what evidence can be adduced to sustain the absolute assertions here discussed, which are so discordant with a great number of well-established standard cases?

Doctors Lasègue, Touzelin, and Legrand du Saulle had to report on the mental condition of a financial agent, whose wife asked for a separation *à mensa et toro*, as he was subject to fits, with every appearance of larvated epilepsy, during which he would accomplish the most extravagant dangerous acts, in an unconscious manner, with an uncontrollable tendency to wander about without aim and with complete amnesia after such strange attacks. In one of them he automatically started on a journey to Marseilles; and, on another occasion, he went off to Bombay.* He was violent, easily inflamed by anger, eccentric, and incessantly planning means of vengeance against his wife, who finally determined not to receive him in her house. One day, in November, 1875, this larvated epileptic, accompanied by a young son who had remained very much attached to him, called on his wife, and as she persisted in her decision not to receive him, and so expressed it to him from inside the house, without opening the door, he, in reply, signified to her his determination to commit suicide if she did not yield to his entreaties to let him in; and, as the door continued notwithstanding closed, he then and there killed himself. But this was not all, for immediately after the son also blew out his brains with the same revolver used by his inanimate father, this fearful catastrophe being the closing scene of a case that exhibits the distinctive traits of psychical epilepsy.

Henry Thouviot was declared by Doctors Bergeron, Blanche, and Lasègue as subject to impulsive insanity, with previous epileptiform accidents, though not being epileptic at the time of the murder for which he was arrested; but, after Thouviot's close examination at Bicêtre, it was recognized by Falret, Legrand du Saulle, and Berthier that he had several diurnal and nocturnal fits, and that

* Legrand du Saulle, from whose work "*Etude Médico-Légale sur les Épileptiques*," Paris, 1877, we take the chief points in this and the two following instances, as regards the psychical phenomena just related, as facts unprecedented in science, although we had pointed out such singular automatic acts as peculiar to *cerebral*, or *psychical*, epilepsy, and recorded in 1873, three instances of unconscious travelling while the patient was in this state, in our communication on Epileptic Insanity, distinctly establishing unconsciousness as the essential characteristic element of every manifestation of genuine epilepsy. Sardien has also reported the case of a carpenter, who was epileptic, and travelled sixty leagues from home, returning from this long journey entirely ignorant why he had undertaken it.

he had been an epileptic for a long time. Thouviot suffered from fits of giddiness, with lividity of the face, dull noises in the ears, and irresistible wandering, without object, about the streets. At other times he experienced a propensity to kill somebody, and was then irritable, angry, emotional, prompt to any act of violence, and incapable of being at rest. Feeling in this condition on the 11th of June, 1874, he leaves his place of occupation, buys a cheap knife, and after dinner wanders at random about the streets, until he met with a prostitute, and goes to pass the night with her. The next morning, after dressing and partaking of some coffee with his hostess, he attentively watches her, with the knife drawn from his pocket held in his hand, reflecting, whether he had not come across an easy victim; but he is suddenly overcome by the thought that he may be judged as a thief, or slayer of girls, and goes away. He again returns to rove about the streets and boulevards, with the knife open in his pocket, until two o'clock in the afternoon, when he entered a restaurant, in Rue Cujas, where he mechanically asked for something to eat, and, while waiting for it, he writes a letter stating that his fate was to go either to the bagnio or die on the scaffold; that he is about committing a crime he cannot avoid, and that he does not know whether to kill the lady at the counter or the servant girl, who, at last, fell his victim as she served him with the dishes he had ordered. Arrested on the spot, Thouviot seemed calm and lucid, and throughout five months that he remained at Mazas under observation, he did not exhibit any apparent sign of epilepsy or insanity. Once he attempted to commit suicide, but was prevented by his companions. In 1869, being at Havre, working as a cook, he fell unconscious in the furnace, and narrowly escaped being burnt to death. He came, then, to Paris, and there he felt a strong inclination to murder the servant girl in the milk shop, where he was employed. "I fixed it so," said he, "that she had to go down the cellar, at least seven or eight times, without power to decide myself; I did not dislike her, for we were on friendly terms together. Lastly, I started away, like a madman, and remained absent from the shop about five days, living on a few *sous* I happened to carry with me, and sleeping anywhere in the open-air."

In the celebrated case of Count Gustave Chorinski, we find him subject to violent fits of motiveless anger and aggression, accomplishing periodically against his family or any of the bystanders the most extraordinary eccentric acts of violence, exchanging senseless compromising letters with his mistress about the murder of the Countess, as also wanting altogether of free-will in the participation in her poisoning, besides other psychical phenomena pointed out by Morel, as signs of paralytic epilepsy, of which disease Chorinski died eighteen months after his imprisonment, within the time prognosticated by Morel, and with every anatomico-pathological evidence of paralytic epilepsy confirmed by the autopsy.

Dagonet cited at the International Congress of Mental Science, held in Paris, in 1878, the case of an epileptic, who in one of his fits of blind fury murdered a keeper, and severely wounded another, at the Asylum at Marseilles, and who, when returned to consciousness, had a dim recollection of his furious acts of violence against the keepers, but, however, remembered distinctly that the latter had ill-treated the patient under their charge, which drove him to the outburst of fierce violence during his maniacal excitement that lasted for nearly three months.

In the case of the epileptic who murdered Dr. Geoffroy, the Superintendent of the Lunatic Asylum at Avignon, and whose fits were preceded by a feeling, or *dream*, as he called it, starting from the stomach to reach the brain, the execution of the murder took place under the following deliberate well-planned manner. The patient, who heard, for several days, voices from a secret society telling him that "if he did not kill the physician, he would be unhappy for the rest of his days;" went early to the Asylum workshop, waited for Dr. Geoffroy in the vestibule between the shop and the doctor's cabinet, and as the doctor delayed his visit, he became impatient, and calling on the director, he inquired after the chief physician, pretending to be ill. He was then informed that the doctor had just arrived, and was visiting the wards. He thereupon went to wait at the door of the doctor's office, alone, in the position of a man suffering from a hurt, leaning on the left leg with the right hand concealed under his vest. He addressed himself to Dr. Geoffroy, without changing his position. The doctor, without mistrust, approached, and no sooner had he stooped to examine the cause of ailment than he firmly surrounded the doctor's chest with his left arm, and quickly stabbed him in the left side of the chest with a pair of shears, the blades of which he had fixed in a cross way by tying them firmly with a pocket-handkerchief. He subsequently became furious, and the doctor died an hour and a half after.

"Premeditation," as Dr. Laurent says in his interesting report of the case, "could not be denied here; but it would be impossible to admit any power of judgment. The struggle which took place within himself, and which the patient committed to nobody (a silence that may be ascribed to the natural pride and high ideas he entertained of himself), had no more witness beyond an unsound reason incapable of reaching impartial decisions. The moral conscience being deranged, every resistance on its part to the most evil impulses was rendered impossible, and within the space of a few hours this lesion originated, to persist for a certain time and disappear, and to recur thereafter at intervals of variable length. Subsequently, this murderer would feel remorse and regret for the physician whom he loved and killed; while under morbid influences, he

would be, on the contrary, controlled by homicidal impulses, and would approve of the crime he had committed. What a lesson does this dreadful event teach to specialists, to medical witnesses who are to guide the judgment of the courts, and to magistrates called upon to pronounce on the motives of the most extraordinary deeds."*

Who would deny deliberation in the case reported by E. Pivion, of a female epileptic at the Salpêtrière, who, in one of her nocturnal fits, gets up from bed, goes to the kitchen to look for a knife, and returns to try to mutilate her husband, who was lying in bed with her, and who had to struggle desperately and to call for assistance to save him from such terrible assault?

We could yet present an endless list of classical cases to demonstrate how carelessly rather than falsely those not practically acquainted with the distinctive psychological phenomena of the epileptic neurosis, by looking at them in an isolated detached manner, attribute to every symptomatic mental episode of the disease a significance which it has not. Dr. Clouston, whose eminently practical sound teaching on mental disorders is universally acknowledged, pointedly reports about an epileptic, that: "On no less than two occasions did the attendant find that, while in the irritable state, he had stolen another person's stocking; had, when he was out walking, put a stone in the toe of the stocking, and twisted up the leg of it, and made an instrument with which, on one occasion, he stood ready to fell an attendant, and on another occasion had intended to fell myself, and that he carried about this stocking at the one time for several days; at the other, I have reason to suppose, for at least a week. After he came to himself, and the epileptic irritability passed away, he brought out the stocking, and told the attendant and myself. Now, if that man had committed murder, most unquestionably it would have been a planned and premeditated murder, as much as if he had been no epileptic at all, and yet the whole thing was owing to the epilepsy, and of course he could not be held responsible."†

There was at the Asylum a German sailor, who became epileptic upon a fracture of the skull. His fits were always attended by the fiercest paroxysms of furor we have ever witnessed, and preceded by a stage of sullenness and unpro-

† "Journal of Mental Science," April, 1877, Vol. xxiii, p. 142.

* Baillarger, "*Archives Cliniques des Maladies Mentales et Nerveuses*," Tome i, p. 222.

voked aggression. One afternoon this patient, during one of his maniacal fits, induced another demented and very mischievous epileptic to join him in a sly assault against one of the keepers, but both were immediately overpowered and secured, without their premeditated violent attempt having the dreadful results of this similar remarkable case related by Legrand du Saulle.*

"The 28th of January, 1868, in the afternoon, the soldier K— was committed, as a lunatic, to the Asylum at Marseilles. He was an epileptic, but unknown to be so in his regiment, and on admission suddenly declared that he would not work, threatening the keeper with his fist. On this account, he had to be transferred to the division for agitated patients, where he met with another epileptic, B—, relatively quiet, and without the strait-jacket. K—and B—confided to each other their respective griefs, and decided to revolt against any who should attempt to restrain them. Thereupon, each pulled out an iron bar from the window, and armed with it, started knocking down first one of the keepers, and then a second who came to his companion's help, fiercely crushing the skull of their cadavers. They then directed their steps towards the entrance of the Asylum, brandishing their iron bars, but finding the doors closed, they returned to search the pockets of the keepers for the keys, and with them passed out into an adjoining division, where they were at last disarmed, overpowered, and secured with the greatest danger to the officers of the Asylum."

Shortly after this horrible scene, K— declared himself very unhappy, cried desperately, pretended that he felt annoyed, that he suffered from stomach-ache, and wanted to see his mother; then he became again furious, uttering threats of death, and trying to assault the keepers who brought him his meals. He told the presiding magistrate and the *Juge d'Instruction* that he had seen flames before his eyes, that he heard voices speaking of murder, that he thought they were to kill him, that the keepers were truly dead, and that they would not resuscitate, as he saw their brains spattered on the floor. He did not exhibit the least regret or remorse.

As to B— he ran into a state of great prostration; he remembered receiving the iron bar from K—, but did not recollect what had happened afterwards, and learnt with the coolest indifference the cruel death of the attendants.

Dr. Yellowlees, while the relation of epilepsy to criminal responsibility was under discussion at the Medico-Psychological Association in February, 1877, remarked, in reference to a distinction made by Dr. Batty Tuke between epileptics and epileptic lunatics, and between the acts of violence done by the

* *Op. cit.*, p. 78.

one and by the other : "I am not disposed to make that distinction so marked as he does. I think that any act of violence committed by an epileptic would be very much the same as an act of violence committed by an epileptic lunatic. I do not see that you can differentiate the two violences. If a man has epilepsy, a tendency to violence is one of the normal manifestations of the disease, whether he has shown former insanity or not. Dr. Tuke makes a remark which is generally true, that deliberation is not characteristic of epileptic violence. I do not know that he is justified in saying 'never.' As a rule, certainly, what he said is true, that epileptic violences are abrupt, sudden, reckless, and not planned ; but I am not sure that an epileptic is never a scoundrel, and that he cannot plan mischief and carry it out just as others do."*

These remarks are very correct, except in saying that, *as a rule*, epileptic violences are abrupt, sudden, reckless, and not planned ; for, as we have already demonstrated, there is a large proportion of cases in which deliberation and planning distinctly precede the outburst of epileptic violence. We cannot understand why such an absolute and inaccurate idea should be propounded, with so many facts to the contrary staring us in the face ; to the overlooking of which facts, errors in diagnosis, and the unsatisfactory way in which medico-legal questions on epilepsy are dealt with, are most frequently due. Let the records of ordinary epilepsy or of epileptic insanity—for unquestionably, as Yellowlees truthfully asserts, there is no difference whatever in the impulsive explosions to which both aspects of the disease might give rise—let all these records, we repeat it, be attentively analyzed, and we shall be at once struck with the motive, the premeditation, and the planning disclosed in a large number of them ; and, on carrying the inquiry into the frequent instances of *petit mal* in which the automatic impulsive act may be of no great consequence, without definite duration or form, or suddenly becoming abortive in its incomplete explosion, and springing from some real or delusional feeling or thought, we shall be convinced of the improper light under which the psychical derangements of epilepsy have been regarded in reference to the important point under consideration. Nothing illustrates better the manifestation of our latent animal instincts in the more or less purposive execution of the automatic acts related to the epileptic fits than a case described by Gowers, of a lad of sixteen, who, after failing in one of his fits, "in an attempt to bite an attendant's hand,

* "Journal of Mental Science," April, 1877, Vol. xxiii, p. 141.

seized the corner of his pillow between his teeth, and throwing his head back, shook the pillow just as a dog shakes a rat, or as the lion shook Livingstone.”*

Lasègue† is the only author, so far as we know, who has openly recognised the important bearing of the facts here maintained, for he declares that “the suddenness of the epileptic outbursts, less absolute than generally believed, does not exhibit the same degree of hesitancy nor the striking delay observed in the execution of insane acts from conscious impulses.”‡ These impulses are the offspring of uncontrollable transient explosions, determined in their inception by the idea that hangs to the obsession, or again by a dread of committing the act suggested by the sensorial derangement. The act, as such, assumes somewhere and somehow, even in its most sudden instantaneous forms, a premeditated or planned aspect, which answers to its mode of successive elaboration, and leads most always to an unaccountable misdeed. Once the act is accomplished, the paroxysm, when not of an epileptic kind, ends ordinarily in a quick, sudden way, the patient regaining his natural intellectual activity, with a sufficient control and clearness to devise the means of evading the legal consequences of his culpable conduct. In one word, the distinction between the two kinds of sudden impulsive outbursts, so much alike at first glance, is, as pointed out by Lasègue, that while unconsciousness stands prominently as the characteristic distinctive of any act of violence perpetrated during the manifestations of the epileptic neurosis, consciousness is, on the contrary, never lost in fits of sudden impulsive insanity, which, though uncontrollable, scarcely ever show the overwhelming fascination of the epileptic fit, the patient being capable of recollecting the paroxysm in all its details, and quite as conscious of the impulse as of its coherent consecutive acts. In either instance, and this is of the utmost importance, and is generally overlooked, the original source of the transient fit is a morbid conception, whether impressed upon the sensorial regions of the brain by a precursory real emotion, or outer imitation, as in the two first of our cases and in those of the convict at Nimes, and of Rœgiers, &c., or by some subjective inner feeling, the offshoot from a delusional groundwork that brings forth the excitation of sensory motor processes concerned in the insane abrupt act

* “Epilepsy and other Chronic Convulsive Diseases.” London, 1881, p. 140.

† “Du Délire par Accés, Extrait des Archives Générales de Médecine,” Janvier,” 1875.

‡ *Loco. cit.*, p. 17.

automatically accomplished and elaborated in both cases in a coherent, logical manner, which necessarily involves a more or less considerable degree of deliberation. Let us notice, however, that, Lasègue, in setting forth the exact diagnostic distinction between the two insane fits of violence here considered, in open contradiction with his own assertions, cursorily remarks that, "the epileptic strikes without motive; he kills for the sake of killing, and does not seem to have been even mastered by the thought of doing mischief;"* this is indeed an unqualified declaration we are at a loss to reconcile with the preceding accurate and sagacious observations of the eminent French alienist. Finally, even in somnambulism, as shown by Krafft Ebing, we may find that the unconscious state does not exclude premeditation in some of the acts of violence accomplished during such psychical condition.†

The foregoing are not exaggerated speculations, but the only legitimate conclusions to which we are led by an unbiassed synthetic study of the psychical symptoms of epilepsy. It is true that we cannot disclose in every instance the hidden source of the reflex sudden explosion; but this should never be a reason to disregard so completely their involuntary nature, nor to look upon the morbid irritability of epileptics as no plea of excuse for the reckless acts to which it might give rise. This question has nothing to do with sentiment; the psychologist taking his stand on material facts, which he can grasp, is capable of appreciating the conditions that underlie the functional disturbances of the cerebral centres, and of estimating the influence of every agency that comes into play in the complex processes involved in the evolution of those several actions which constitute the substratum of our mental existence, *i.e.*, in our consciousness arising from every sensorial impression on the brain, and intimately linked with volition, as it is potentially affected by every change in the exceedingly complicated and delicate functioning of the whole nervous system. We cannot get outside of these material facts, and by dissociating them, and taking strict account of every positive and negative physical element correlative with every defect or loss of consciousness, we may, without fear of upsetting old popular prejudices, demonstrate to every practical mind that, whether over-increased or lost, the functional activity of the sensori-motor cerebral arrangements in epilepsy is brought into operation by

* *Op. cit.*, p. 15.

† "Recherches sur la Folie Passagère," Trans. by Dr Doumic, in "Annales Médico-Psychologiques." Paris, 1870, 3e, série, Tome iii, p. 218.

ordinary influences and processes which cease to be healthy, because they become uncontrolled, or completely lost, upon exhaustion of some or the whole of the said arrangements consequent on the epileptic discharge. Whereas, any epileptic who by reason of his mental infirmity is prevented from controlling his own conduct, is not responsible for what he does, nor could he be considered with proper capacity to judge that the act which he proposes to do is wrong; such being essentially, (as justly laid down by Mr. Justice Stephen) the only true criteria of criminal responsibility. Beyond this clear point, it will be idle to engage ourselves in further disquisition, not within the scope of this paper.

But why should we attempt to make the old garment cover the new fact, and why disregard the fact that the highly unstable state of the nervous arrangements renders them useless for normal functioning, as Hughlings Jackson teaches us; or, putting it in the forcible terms expressed by Delasiauve when discussing the case of the young student at the seminary of Hix, who stabbed another student while asleep, and who had two convulsive fits of a suspicious nature during the very year of the homicidal attempt, which he premeditated for ten or twelve hours—"It is certain," goes on to say the eminent French author, "that on passing by an epileptic we elbow one who might be an assassin, and that epilepsy, through the fancies more or less delusional that it originates, furnishes a considerable share of the crimes reported by the daily press and ascribed to mental alienation."*

It is precisely by studying the silent manner in which the irritability of the nervous centres induces the characteristic outbursts of the disease, that we can come to a correct appreciation of its singular psychological aspects, and to understand from clinical observation the inhibitory phenomena that take place in the highest centres from modifications in the energy to increase and to control their resistance, which underlie the unconscious automatic acts that may precede or follow the fit, when not by themselves constituting the whole conspicuous signs of the psychical manifestation of the epileptic disease.

The chief difficulty in the study of epilepsy is to arrive at the diagnosis of the so-called slight fits, which are often so imperceptible in their outward physical symptoms, that the attack may possibly pass unnoticed even to those who might be looking at the epileptic. These slight fits, again, are commonly

* "Journal de Médecine Mentale," Tome ix, p. 245.

overlooked, because they are reduced, on frequent occasions, to sudden outbursts of ill-temper, or of violent irritability, in individuals who look otherwise in fair health. No doubt that, if instead of simply becoming irritable and quarrelsome in these fits of *petit mal*, the epileptic were seized with wild maniacal excitement along with those symptoms, the case would then be considered as carrying in itself the requisite sign to render the irresponsible nature of any unlawful act originating from such epileptic seizure obvious. But, how could we, on the other hand, detect the arbitrary distinctive pathogenetic elements between the two kinds of cases? where would be the proof that in the first the patient suffers from a different disease, or from no cerebral disease, and is besides possessed of the self-control, lost in the second case, to overcome the outburst of ill-temper or violence, which stands as the unmasked exponent of the paroxysmal discharge in some part of the brain, *i.e.*, the fit of *petit mal*, whose consequences may nevertheless prove worst to the mind, for it is acknowledged that the amount of outward spasmodic manifestation is not in relation to the real gravity of the epileptic fit. These recognised facts suffice to demonstrate why it should be unjustifiable to reject as a plea of excuse for wrong-doing the irascibility of epilepsy, which is altogether distinct in every respect from that caused by gout, or the peevishness characteristic of one stage and form of phthisis, and that which accompanies certain of the physiological processes and changes in life, for none of them exhibits the unconsciousness that comes attached, in more or less degree, to the psychical disorders produced by epilepsy.

To dispose of this matter we could not better express our opinion than by repeating with Falret—"We cannot, indeed, according to our idea, deprive a whole class of persons, whose disease has already entailed upon them so many misfortunes, of the exercise of their civil rights, and this, when experience has shown that, notwithstanding changes of character and temporary weakness of mind, these persons may enjoy in the interparoxysmal periods long intervals of reason. We think, therefore that, generally speaking, in a doubtful case, one ought to incline the scale in favour of validity of action whenever the point is discussed in civil cases, whereas it should be inclined in favour of irresponsibility in criminal cases."*

We now come to the close of our remarks on the subject of epileptic violence, which has been specially analysed by few

* "De l'Etat Mental des Epileptiques." Paris, 1861, p. 82.

physicians, and by none, so far as we are aware, in the light in which we have presented it. The matter affords a wide field for speculations, as generally all inquiries are directed to the nature of the act of violence itself, not looking beneath it right down into its cause, for which reason little attention is bestowed either upon the prominent immediate relations between the sudden outburst and the unappreciated psychical state of the epileptic which occasioned it, or on the amount of mental defect or unconsciousness as related to the perverted feelings which originate the fit with all its inevitable sequels. We have endeavoured to avoid such oversights in our inquiries, and we believe that sufficient proofs have been adduced, gathered from the clinical records of classical authors, and from those of our long careful study of epilepsy, to warrant the following conclusions:—

There is no essential difference between the automatic sudden impulses which occur after an ordinary fit of epilepsy and those committed by an epileptic lunatic during a frantic paroxysm. In either case the psychical condition that underlies the act is the same; in both instances the violence is automatic.

Sudden impulsive acts related to the psychical manifestations of epilepsy very often evince in their automatic execution a coherent planned purpose, and a deliberation which can be disclosed even in the co-ordinate intellectual operations during the development of the fit, and in those instances that might, at first glance, appear motiveless; while the outburst or unconscious violence is again by no means so abrupt and instantaneous to render, as hitherto generally thought, deliberation impossible.

The irascible outbursts of epileptics are frequently the psychical exponent of unobserved fits of *petit mal*, that may easily culminate in criminal catastrophes, and, therefore, present a clinical and medico-legal value of the utmost importance.

Epileptics cannot be held responsible for any act of violence perpetrated during their unconscious automatism, which they have no power to control, nor capacity to judge.

On the Necessity of all Medical Students attending a Course of Lectures and receiving Clinical Instruction also in Psychological Medicine. By EDWARD E. MOORE, M.D., B.Ch. Dubl., Asst. Med. Off. District Asylum, Downpatrick.

Few, I think, will attempt to deny that it is desirable that all medical students should attend a course of lectures on the important subject of Mental Disease. And further, that these lectures should be compulsory, no matter what the university or medical school may be at which the students matriculate, or where they may intend to take their degrees or diplomas. Some there are who may object to these lectures being compulsory, for the reason that this course of lectures would be the addition of another subject to the already lengthened curriculum of medical studies. I think we are all agreed that the medical student of the present day has enough, and more than enough, of subjects to occupy the short term of four years that is usually allotted to his studies.

It is almost impossible for a student of ordinary ability, in the limited time for study at his disposal, to obtain a sound knowledge of the most important branches of his profession, and of the less important ones the student nowadays can only gain a superficial knowledge.

There are two ways of meeting this objection of the addition of another subject to the student's curriculum.

First, by omitting some subject of less importance from the present curriculum; or, secondly, by lengthening the student's period of study, and making it five years instead of four.

I think the adoption of one or other of these courses is the only way of meeting the objection I have alluded to.

Much can be said on the relative merits of each course, but at present I don't intend to say anything with reference to either. I have only mentioned them for the purpose of answering those who might object to the addition of psychological medicine to the student's course of study.

The study of mental diseases, and the care and treatment of the insane, are subjects of far more importance now than they were a few years' back, and they are becoming more so day by day, for the simple reason that the public are becoming better acquainted with the laws relating to the insane and the manner in which those laws are carried out.

Recent cases which have been investigated in the English

courts prove this, for these cases have been brought prominently before the public, and the conduct of the medical men engaged in them has met with severe and hostile criticism.

It being then a fact that the knowledge of mental diseases is a subject of great importance to all medical men, I hold that it is a blot on the curricula of the vast majority of our licensing bodies that they don't make the study of psychological medicine in some form or other compulsory, and oblige each student before he goes in for his final examination to produce a certificate of attendance at a course of lectures, and the having also received clinical instruction on mental diseases. To the Royal University of Ireland and to the Victoria University, belongs the honour of being the foremost amongst the teaching and licensing bodies of the United Kingdom to give a place to psychological medicine in their curricula. The Victoria University includes mental diseases amongst the subjects of examination for the M.B. degree, whilst the Royal University compels each student, before presenting himself for the degree examination, to produce a certificate of having attended a course of lectures (not less than twenty-five) and clinical instruction on mental diseases.

The other teaching and licensing bodies simply ignore the subject altogether.

A summer course of three months' lectures would, I think, be quite long enough to enable students to obtain a fair degree of knowledge of this important subject.

I consider lectures, however, and the amount of knowledge to be gained from them, of very secondary importance to clinical instruction. This is true with regard both to medicine and surgery generally, and it is equally true with regard to mental disease in its multitudinous forms and varieties. Lectures on mental diseases are all very well and useful no doubt, in their way; but without being brought face to face with the different classes of patients in our asylums, how, I ask, can a student obtain any sound, practical and lasting knowledge of the many phases of insanity?

We compel our students to spend hours and hours learning the uses of the ophthalmoscope and microscope, very useful and instructive instruments, no doubt, but I would like to know how many men when they have obtained their diplomas continue to use these instruments as aids to diagnosis? I am certain that very few indeed of the general practitioners who are scattered far and wide through the country ever handle

them again. These men lead busy, active lives, and have little time or opportunity at their disposal for the use of these instruments.

Still, the knowledge of the uses of the ophthalmoscope, &c., is very important to all medical men, and I would be sorry to think that any of our students lacked that knowledge.

I only mentioned these instruments for the sake of pointing out that we compel our students to acquire a knowledge of them, which as soon as they become qualified they cast aside, and at the same time we entirely neglect and pass over psychological medicine, which is a subject all general practitioners should be particularly intimate with ; the result being that our students leave our schools just as ignorant of the subject as when they entered them.

What follows, then, as a natural consequence?

The newly-qualified practitioner is cast adrift with a diploma in his pocket which gives him the legal right to examine and certify as to the sanity or insanity of any of Her Majesty's subjects, whilst at the same time he may be totally ignorant of everything connected with the subject of mental disease, and may very likely never have seen a lunatic in his life.

What can be more absurd than such a state of affairs ? If it was not a most serious matter, it would be laughable in the extreme.

The neglect of psychological medicine in our medical schools is wrong, and needs reform at once. Sooner or later public opinion will be roused on this subject, and will compel the schools that have neglected doing so up to the present to place mental diseases amongst the subjects to be taught their students.

I have no doubt that there are plenty of medical men who have never seen a case of insanity until they have been asked to see a patient and to certify as to his mental state. Is it fair, I ask, to these men, or to the alleged lunatic, or to the public generally, that they should have to give an opinion on a case, the nature of which they know next to nothing about, and very possibly may be totally ignorant of ?

It is not a simple matter always for an inexperienced medical man to examine an alleged lunatic and to satisfy himself that he is really insane.

Some men may think it is a very simple affair, but I do not.

It is becoming every day more necessary that medical men should be instructed in the subject of psychological medicine, and be well and thoroughly acquainted with the laws relating

to the insane, and also that they should be well skilled and capable of making a diagnosis in a doubtful case of insanity. To prove this we have only to read the reports of the many actions in which medical men have been the defendants, and where they have been mulcted in heavy damages by juries that have found the plaintiffs sane, although the medical men have, to their cost, certified the contrary.

It is becoming quite a common occurrence now for actions to be brought against medical men for making what are said to be wrong diagnoses in cases of alleged insanity.

So common is this becoming in England that many medical men have altogether refused, I believe, to certify in cases of alleged insanity until the law is altered, rightly arguing that it would not pay them to run the risks of actions at law, which would cause them great expense, and much worry and annoyance.

Medical men can get up the lunacy laws from Acts of Parliament, but the diagnosis and treatment of insanity cannot be so learned; it must be taught in our asylums, and can, I hold, be taught there only. Such being the case, there is no remedy for it but to commence at once, and give all our students that clinical instruction which will be so necessary and important to them in after life.

I believe that this is a matter of importance to all members of the commonwealth, and that such is the case I will endeavour as briefly as possible to point out.

For the purpose of doing so I will divide the community into three classes, and then consider the importance of the subject to each class. The three classes are: 1st, medical men; 2nd, the insane; 3rd, the public generally.

1st. To medical men more than to any other class of the community is this question of vital importance, for as the law authorises them to certify as to the sanity or insanity of an alleged lunatic, so also does the law hold them responsible for making wrong diagnoses, and this responsibility often carries with it heavy damages given by juries against medical men, who, to the best of their abilities and with honest intentions, have tried to carry out the law as they find it, but who, unfortunately for themselves, have lacked that clinical experience which would have prevented them falling into the unpleasant position of making what are said to be wrong diagnoses.

If the law should compel medical men to acquire this clinical experience and then hold them responsible, it would be quite fair, but at present it holds them responsible, but does not aid

or assist them in any way to gain the practical knowledge they so much require. That, I think, is unfair, for they cannot provide this instruction for themselves, no matter how much they may long for it. The knowledge that enables a man to make a correct diagnosis in a doubtful case of insanity cannot be obtained from books; by clinical instruction alone can it be acquired.

Though this is undoubtedly true, how very few medical men are there who have ever gone through an asylum even as a matter of mere curiosity, and those who have had the opportunities of acquiring practical knowledge in our asylums are still fewer. It does not require a medical man to make a diagnosis in a case of acute mania; any man almost with common sense could diagnose such a case. There is as little difficulty about the diagnosis of dementia or idiocy, and the same might be said with reference to a case of acute melancholia. In those cases, however, where a medical man is called in and sees the patient for the first time, and when he is enjoying a comparatively lucid interval, or where the patient is on the border-land between sanity and insanity, it is then that the medical man finds himself in a difficult position, and from want of clinical experience is doubtful as to what his diagnosis should be. That errors of diagnosis can be made, and are made in such cases, I know from experience, but to prove that these errors do occur I will quote from a very high authority. The authority I allude to is the 32nd Report of the Inspectors of Lunatic Asylums in Ireland for the year 1882. On the eighth page of that report, in speaking of the committals of dangerous lunatics, the Inspectors say: "So prevalent throughout the kingdom is the practice of magisterial committals to asylums, that on the slightest pretext, and it has so happened without any reasonable pretext whatever, males and even females of perfectly sound mind have occasionally been sent as dangerous from distances of thirty or forty miles to district institutions."

Can any language be stronger than that, and does it not prove emphatically that medical men are liable to make erroneous diagnoses, and so mislead magistrates into committing sane individuals to an asylum?

It is from want of practical knowledge alone, I think, that such errors of diagnosis can arise. If our students were made familiar with the many phases and varieties of insanity, they would, as physicians, be able to judge whether a man was eccentric or mad, or again whether an alleged dangerous lunatic was really so or only a man of violent temper. In these

cases the medical man who had some clinical experience of insanity would not remain in doubt long, for he would be able to recognise the absence or presence of symptoms and signs of mental disease in his patient that an inexperienced practitioner would pass over as of no importance.

When giving his opinion as to the sanity or insanity of an alleged lunatic, the physician's duty is simply limited to making a diagnosis, and I think rightly so. A medical man (according to Dr. Sankey, "Lectures on Mental Disease," 1884, page 409) is most frequently consulted as to the mental health of an individual for the following reasons:—

1. To give an opinion on the capacity of a person to execute a legal instrument.

2. To relieve the lunatic from the responsibility of his acts.

3. For what is called the imposition of restraint. All cases of alleged insanity that come under any of the above headings are cases of extreme responsibility for any medical man to express an opinion upon, and ought not to be left to the sole decision of a physician who has no practical knowledge of insanity.

Take, for example, a case where a medical man has, in a court of law, to give his opinion as to the sanity or insanity of a testator.

It comes to this. The medical man has to depose on oath as to the diagnosis he made of the testator's competency or incompetency to make the will in question. In such a case the opinion of the medical witness carries great weight with the jury, and as it does so, is it not, I ask, a matter of vital importance (when the welfare of a large family may depend on the evidence) that he should be competent himself to decide as to the competency of his patient to make a will?

In some such cases there can be no doubt on the subject, but in many a case of a disputed will, where the testator has been labouring under a slight attack of mental aberration, how can his medical attendant be capable of judging of his competency to make a will, unless he has had some practical acquaintance with similar cases of mental disease? Again, when a medical man has to depose on oath as to whether a criminal, who is alleged to be a lunatic, is insane or not, and if he is insane, whether he was responsible for his actions at the time he committed the crime; in other words, whether he at the time knew he was doing wrong, it is often a very difficult matter for any medical man to give an opinion on, and his diagnosis in such a case is of vast importance to the accused. If, for

instance, he decides that the accused is sane, he may be wrong, and may, in plain English (when the accused is charged with the crime of murder), be signing the death-warrant of an innocent man, in the sense that if he happens to be insane, he is in the eye of the law innocent of the crime.

If, on the other hand, he decides that the man is insane, he may be permitting a blood-stained ruffian to escape the extreme penalty of the law, the just reward of his evil deed.

In all such cases where a man is accused of murder and is supposed to be insane, his mental state should be examined into by two or more medical men, who have made psychological medicine their special study.

The responsibility in such cases is far too heavy to be laid on the shoulders of any one medical man, and particularly is this so when the medical man may be without any practical knowledge of mental diseases.

Then, again, as to the imposition of restraint. Would we think for a moment of asking a man who never saw a case of typhus fever to treat such a case, when we could obtain the services of a man that had great practical experience of the disease? or would we like a surgical operation to be performed on ourselves by an inexperienced surgeon when a skilled operator was at hand?

Surely not. Yet when it comes to depriving a man of his liberty, we call in the nearest medical man to fill the necessary certificate, never considering for a moment whether he has had any practical experience in the treatment of the insane, or, indeed, whether during his whole life he has seen a lunatic before. Is such treatment of the alleged lunatic fair? It will be at once admitted that it is not, and that he should always, when possible, have the benefit of an experienced physician.

The liberty of the subject in this country is valued highly, and very justly so, and every man is proud of the freedom which he enjoys. Is it right then, I ask, that a man should be deprived of that liberty which is his birthright and proudest boast, and placed under restraint on the medical certificate of a man who may be utterly incompetent to decide as to whether he is insane or the reverse? It is not right, but wrong, and such a state of affairs needs amendment at once. It is not fair to an inexperienced medical man to ask him to fill a certificate committing a man to the restraint of an asylum. And unless the case is one of unmistakable insanity, the medical man, I think, is decidedly acting foolishly if he signs such a certificate, for the doing so may make him the defendant in an action at

law as soon as the patient leaves the asylum and puts his case in the hands of a solicitor. We all know there are plenty of solicitors ready and willing to take up such a case when the grounds for an action are of the slightest, and even when there are no grounds at all.

The result of such action, as I before said, may be most unpleasant for the medical man.

2nd.—To the insane themselves this is a subject of deep import. The lunacy laws were partly called into existence for the protection of the insane.

The law protects the lunatic from himself and his own mad acts; but still the law has to depend on a medical man to certify that the alleged lunatic is really of unsound mind.

Here, again, we at once see how important it is that all medical men should have a practical knowledge of insanity, so as to be able to make a correct diagnosis as soon as possible, and by doing so to place the lunatic, who is irresponsible for his actions, in an institution where he will get the best of care and treatment, and at the same time be protected from himself. How many cases of suicide occur from neglect of placing those labouring under great mental depression (which is often the earliest symptom of insanity) under restraint as soon as their condition of mind has been recognised? Such instances are of frequent occurrence, and in many of these cases medical men have been in attendance on the unfortunate people, but, from want of practical knowledge of insanity, they have failed to recognise soon enough the mental derangement of their patients, and have not advised their patients' relatives or friends to keep a close watch on them, the result too often being the suicide of the patient, and the cutting short of a life that might have been essential to the well-being of a large family, but which, from want of an early diagnosis, has plunged that family into deep grief, and perhaps into impoverished circumstances as well.

To prove that such cases occur almost daily in our midst, we have only to take up the papers and read the reports given in them of the evidence produced at inquests which have been held on suicides.

If medical men had some clinical experience of insanity and its treatment, I say these unfortunate cases would not be of such frequent occurrence, for they would, by the aid of the knowledge gained in our asylums, be able to recognise them sooner, and, having done so, they would at once warn the friends of their patients to be on the alert.

3rd.—The public also must be protected, and for their

protection were the lunacy laws partly framed. Without these laws lunatics could not be placed in the asylums, which have been built for them at great expense. If lunatics were allowed to take care of themselves, we all know they would be a constant source of danger to the public; in fact the state of affairs would be terrible in the extreme, and the public would suffer under the circumstances more than the insane. The law, however, authorises a medical man to sign a certificate declaring any person to be of unsound mind.

Such being the case, it is quite clear that the public are dependent on the medical profession for protection from the insane. It behoves them, therefore, to look at once, well and carefully into this matter, and it is for them to insist on psychological medicine being made a subject of compulsory study in our medical schools. The public have really the power of making the schools place this important subject amongst the many and various courses of study that the medical students of the present day have to acquaint themselves with, and if the public do not exercise their power in this respect, the present unsatisfactory state of affairs will continue for years, and the medical student's education in consequence will be incomplete.

I have endeavoured thus briefly, and in an imperfect manner, I am aware, to express my opinion on this question.

The importance of the subject is my sole excuse for having brought it forward, and if the few remarks that I have made could in any way further the adoption of the study of psychological medicine in the curricula of our medical schools, and if I have proved, as I have endeavoured to do, that the study of mental diseases is of vast importance to all medical men, the insane and the public generally, I will be happy indeed, and deem myself fortunate.

[Dr. Moore's paper is opportune, inasmuch as the Council of the Association has now under consideration a proposal to enable the Association to examine in Psychological Medicine, and to make arrangements for carrying the scheme into practical execution.—Eds.]

CLINICAL NOTES AND CASES.

Cerebral Localization. Brachial Monoplegia from Cortical Lesion. By WM. JULIUS MICKLE, M.D.

(Specimen shown at Meeting on Nov. 5th, 1884. See "*Journal Mental Science*," Jan., 1885, p. 642.)

J. N., a soldier, admitted in 1875, at the age of 38, having been then insane for three months, and eccentric for four years previously. Of his term of service, 13 years had been in India, and whilst there he had been twice treated, in 1860-1, for venereal "primary sores." There was no history of convulsion, cranial injury, constitutional syphilis, or intemperance.

During the attack, but *before admission*, he had been suffering from acute mania, sudden in its onset; had been in low physical condition, and the subject of hæmatoma auris.

On admission he was still acutely maniacal, and was emaciated. The face had an aged, dried, wizened, sallow, parchment-like appearance; irregularity of a fourth rib existed; slight enlargement of inguinal glands; and interrupted inspiration at the right apex. Weight, 131lbs.; height, 5ft. 7in. R, K.I., Baths, Conium. Hypnotics, *p.r.n.*, &c.

The acute excitement passed away. He became industrious, quiet as a rule, subject to occasional excitement, and to delusion of sombre and morose tinge. He gained 40lbs. in weight.

Passing to the final illness: In 1883 signs of pulmonary phthisis became decided. The urine was free from albumen or sugar. In 1884 phthisis was more advanced; and the bowels became obstinately more or less loose from tubercular ulceration; the stomach, too, was irritable and dyspeptic, and the difficulties in treatment were enhanced by the patient's illusions of taste and smell, and delusions about his food and the remedies given to meet the various indications that arose. Both being taken continuously for months, his evening temperature usually exceeded his morning temperature by from 1° to 2°, 3°, or even 4° Fah. Latterly he grew very pale and sallow, having almost a cancerous look.

Oct. 22nd.—Delirious, noisy, loquacious, swearing, and obscene, abusive, distressed, and self-worrying, disconnected, but monotonously reiterative in his delirious utterances. *A.m.*, pulse 80, resp. 24, temp. 98°; *p.m.*, p. 114, r. 21, temp. 98°. For several days previously his temperature had been ranging between 99° and 100·4°, and the pulse and respiration had been higher. He now refused food, and had peptonized-milk enemata for one day, after which he took his quinine, brandy, eggs, milk, etc.

On the 23rd the delirium continued, and the attendant reported a

convulsive seizure. *A.m.*, pulse 92, resp. 26, temp. 98.4°; *p.m.*, p. 120, r. 32, t. 98°.

On the 24th the delirium had quite passed away. *A.m.*, pulse 120, resp. 32, temp. 97.6°; *p.m.*, p. 92, r. 26, temp. 98°.

By the 26th the bowels had been loose for several days; enemata containing arg. nitr., but later on ac. tannic had been given. There were some signs of inflammatory congestion at the bases of the lungs.

28th.—Sudden palsy of the right upper limb, without any spasm, or loss of consciousness or mental change, or affection of speech, and not associated with abolition of sensation.

29th.—Paralysis more marked, complete in the right upper limb, with some paresis of right lower limb. Tongue protruded very slightly towards right; face apparently not affected. Respiration variable, and irregularly up and down in rhythm. At midnight, the right fingers twitching, the right upper limb the warmer.

30th.—Respiration more irregular; left ptosis; patient very restless, but able to reply. Some rusty sputum; some dulness, crepitation, and slightly bronchial respiration, about bases. A dextral epileptiform seizure next took place, affecting the head, eyes, trunk, and palsied right arm, and followed by partial unconsciousness, weakness of both legs, dysphagia, and almost apparent death. Under active treatment he revived, the pulse however remaining feeble, and the respiration being then in cycles, a group of four such lasting 70 seconds, each cycle consisting of eight respirations, of which the last two were long and noisy in expiration and with moist rattles. Later in the day were two more dextral epileptiform seizures; coma; heavy, laboured respiration; death.

The relation between morning and evening temperature usual to this case was reversed on the last three days of life, the morning temp. being 2.1°, 1° and .6° higher than the evening temp. on the 27th, 28th, and 29th respectively.

26th	<i>a.m.</i>	pulse	120	resp	38	temp.	97.6°
27th	"	"	120	"	36	"	99.6°
28th	"	"	126	"	42	"	99.0°
29th	"	"	120	"	44	"	98.4°
30th	"	"	132	"	24	"	99.0°
26th	<i>p.m.</i>	pulse	126	resp.	40	temp.	97.6°
27th	"	"	120	"	40	"	97.5°
28th	"	"	120	"	36	"	98.0°
29th	"	"	126	"	46	"	97.8°
30th	"	"	—	"	—	"	—

Abstract of necropsy, 48 hours after death.—Firm, pale clots, mingled with dark, in the dura-matral sinuses and in the superior meningeal veins; the whole length of the superior longitudinal sinus being partially filled by a very firm and pale, pre-mortem, clot. Some small thin flakes of soft dark blood-coagula on the upper part

of the inner surface of dura-mater. The dura, slightly thickened, was peeled without difficulty from the calvaria. The arteries at base of brain contained a little dark clot. Slight adhesion between dura, and pia-arachnoid, on each side, at vertex. The membranes were stripped with fair ease from the brain. The cerebral grey cortex was rather pale generally; and somewhat wasted in the fronto-parietal region, with slight pial œdema. Both the medullary substance of the brain and the cerebellum were of fair consistence, and rather pale. Fornix softish; basal ganglia pale and flabby; fluid from cranial cavity $1\frac{1}{2}$ fl. oz.

The whole depth of the grey cortex of nearly the upper inch of the anterior central gyrus was reddened, softened, and the seat of punctiform injection and punctiform hæmorrhage. In front, this lesion extended to the grey matter forming the floor and sides of the posterior part of the superior frontal sulcus, and to the marginal strips of the first and second frontal gyri, bounding the latter; behind, the lesion extended across the fissure of Rolando to touch the Rolandic aspect of the posterior central gyrus. The margins of the softening were marked by intense punctiform injection, limiting the lesion, and in parts forming the exact boundary between the grey and the white.

Some partially decolorized clots in the heart; those in its left chambers were partly adherent to the walls and columns. Aorta slightly atheromatous; aortic valves slightly too thick and opaque. Lungs in a state of advanced phthisis, with considerable cavitation of the left, which, of the two, was the one more closely bound to the chest-wall by tough old thick leathery adhesive pleuritic false-membranes. In both lungs, congestion and œdema of the lower lobes, with some pneumonia-patches in the right. Wedge-shaped fresh infarcts in kidneys, two in the left, one in the right; capsules slightly adherent. Spleen firm; liver somewhat so. Shallow, superficial, circular, ulceration of gastric mucous membrane; some tubercular ulcers of the small intestine; a few small, circular, superficial ulcers of mucosa of colon.

Weights, in ozs.: Right cerebral hemisphere, $22\frac{1}{2}$; left, $22\frac{1}{2}$. Cerebellum, $5\frac{1}{8}$. Pons. and M.O., $\frac{7}{8}$. Heart, $10\frac{1}{2}$. Right kidney, 4; left, $4\frac{5}{8}$. Spleen, $6\frac{3}{8}$. Liver, $63\frac{1}{2}$.

Remarks.—The point of chief interest was the precisely defined, acute, red softening, limited to the grey cortex of the upper part of the left anterior central gyrus, to that of the posterior part of the superior frontal sulcus, and of the adjoining margins of the first and second frontal gyri. Partly by putting out of use, and partly by irritating, the cortex, this produced right brachial monoplegia of an absolutely complete character, for the time being; then slight paresis of the right lower limb; occasional twitching of the right fingers; and right unilateral convulsions, without abolition of sensation in

these parts. Other pathological cases have indicated the intimate physiological connection between the left anterior central gyrus and the right upper limb, and the present case gives some support to the views of those who hold this connection to be rather with the upper than with the middle third of the convolution. The lesed left first and second frontal gyri also, in slight degree, represent this upper limb; or, at least, their lesions often have some influence on its functions. The comparative slighness of the affection of the leg is to be expected in a left cerebral lesion situated as in this case. The finally irregular up and down respiratory rhythm, and the final reversal of the relation between *a.m.* and *p.m.* temperature usual to this case were also worthy of notice.

Other interesting points there are, unconnected with cerebral localization, and not taken up here.

Case in Asylum Practice where Seven Ribs were Discovered to be Fractured, after Death.—Reported by HARRY A. BENHAM, M.D., Assistant Medical Superintendent, City and County Asylum, Stapleton, Bristol.

James Clark, æt. 54, married. Admitted into the asylum on 14th December, 1883, at 5.20 p.m. Patient, who has been blind for 20 years past, was reported to be neither epileptic, suicidal, nor dangerous. The medical certificate stated that patient "is imbecile in manner and conversation, and appears totally incapable of taking care of himself." No history was then obtainable. He was first taken to the workhouse, and after being detained there a few hours was brought to this asylum. While at the workhouse he would take no food; on admission, being unable to stand, he was carried from the cab into the waiting-room, where he showed symptoms of excitement. He was carried into the wards, bathed, and put to bed in my presence. From admission, he could not stand without assistance. As he was very restless and tried to roll about, mattresses were placed on the floor of his room to prevent his doing himself any injury. I examined him when in the bath-room, and no fracture or displacement of the ribs was discoverable; owing to his becoming restless and excited when his body was touched, I was unable to apply the stethoscope to his chest. From admission, he had the delusion that all nourishment was poison, and he could only be induced by coaxing to take any.

After his death his wife, to whom I had written, came over and told me that her husband had been under medical care for two years past, since which time he had been obliged to give up his post as teacher of the blind. He had lived at home and kept quiet until about a month previously, when he became excited and refused his food, believing it

was poisoned. He got out of bed, broke the furniture in his bedroom, and also broke a hole in the wall of his room. He had become unmanageable, and had taken very little food for two weeks past, and part of that food he would generally vomit up again. His sister and maternal aunt had been inmates of asylums. The wife was extremely averse to a post-mortem examination, but, being pressed, she consented.

I also received a note from patient's previous medical attendant, in which he stated that he had visited him for more than two years, that at first he complained of dyspeptic symptoms, followed by strange sensations about his head, and a burning sensation down his spine, and that he suffered from sleeplessness and general restlessness; that he, the doctor, "rang the changes" on him, and gave him every form of nervine sedative and tonic he could think of. About two months ago patient became exceedingly stubborn and irritable, and had great rigidity of the general muscular system, which was, to a certain extent, relieved by the administration of chloral and bromide of potassium. At this time he had strongly recommended his removal to an asylum, but the wife refused.

Patient, immediately before admission, had become so violent that he refused any further responsibility in the matter, and insisted on her applying to the poor law authorities.

Extracts from the Case-book are as follows:—

December 15.—Slept well, took no breakfast, but about 9.30 a.m. took a pint and a half of beef-tea, and asked for opening medicine. He was ordered three-quarters of an ounce of castor oil, his breath being very offensive and tongue foul. Pulse was 96 fair; he again resisted careful examination. At night he was ordered half an ounce of tincture of hyoscyamus, as he continued excitable.

December 16.—In a state of maniacal excitement; took nothing. At night he was reported to have been very noisy and excited all day, and to have taken no food, had torn two shirts to pieces, and his pulse was very weak. He was carried on to a couch outside his room, and was fed by me with the aid of the stomach pump. To the feeding mixture was added two ounces of whiskey, half an ounce of tincture of hyoscyamus, and a dose of house medicine. He was restless while being fed, but no violence was used, and, particularly, no pressure was applied over the chest. After this I saw him bathed and put to bed. This was the only time he left his room.

December 17.—Stronger to-day; pulse better, took food well, and was quieter.

December 18.—Refused his breakfast; later took from me two ounces of port wine and a quarter of a pint of beef-tea. His hands were confined in gauntlets, as he tore everything to pieces. At 1 p.m. he took two ounces of port wine and a little milk. His pulse was still very weak. At 2.30 p.m. he took nearly a pint of beef-tea; at 4.45 p.m. he took two ounces of port wine and a pint

of milk; and at 5.30 p.m. he took two ounces of port wine and half a pint of milk. From this time he became very excited, and refused all nourishment. He gradually sank, and died at 7.35 a.m. on December 19.

The extracts from the post-mortem notes which follow were taken by my friend Mr. H. Rimmington Mead, whom, in the absence of the Medical Superintendent, I requested to be present.

Autopsy, 29 hours after death.—Rigor mortis universally present. Left lung, weight 12 ounces; right lung, weight 15 ounces. Both collapsed. Heart, weight 11 ounces. Pericardium full of fluid; right ventricle full of clots. Brain much wasted generally; weight, 36 ounces. Arachnoid membrane dull and opalescent. About six ounces of fluid escaped on the removal of the skull-cap. Both lateral ventricles were full of fluid, and the brain substance was generally congested. On section of the right kidney a small quantity of cystic pus escaped. The seventh to third ribs on the left side were found to be fractured at from three to four inches from the sternum. There were no external marks of injury, and no displacement existed. There was a small quantity of dark grumous-looking fluid effused opposite the fracture of the seventh rib. The ribs were in a very advanced state of degeneration, and almost broke under the finger. Nothing else called for particular notice.

Immediately after the post-mortem I communicated with the Coroner, who held an inquest at the asylum on the 24th December. After a lengthened inquiry, the jury returned a verdict to the effect that patient died of "Exhaustion after acute mania."

Remarks.—This case is interesting in view of the fact that when a patient in an asylum is found post-mortem with broken ribs a suspicion that undue violence has been used by someone connected with the establishment is almost sure to be raised. The above case tends to demonstrate how erroneous such a view may often be. This man, owing to the terror he had displayed on being touched on his body, had, though nothing could be detected from external examination, suggested to me the idea that some injury might possibly have happened to him previous to admission. He was consequently placed under special supervision, and visited at all hours. Mattresses were placed over the floor of his room, so that he should, so far as possible, be safe from injury when restless. On the only occasion on which, as before mentioned, he left his room I was present, and therefore am enabled to express a confident opinion that his injuries had not been received here. Of course it is perfectly well known to the "specialty" that fractured ribs with no displacement may occasionally be found in advanced cases of brain disease which are never detected during life, but

it is by no means always easy to convince a coroner's jury of this. Owing to the precautions adopted from this patient's admission it was not difficult to show how improbable, to say the least, it was that the injuries could have occurred here, nor could any blame be attached to the workhouse officials. My own view is that the fractures were not of very recent origin. His wife's statement to me, after the patient's death, that he, a blind man, had got out of bed when alone in his bedroom and broken the furniture and used such violence as to break a large hole in the roof, indicates, to my mind, a ready way in which the injuries might have been received. The fractures were all situated from three to four inches from the sternum, and the bones were in such a state of degeneration that they would break up on the slightest pressure. There was no displacement of the broken bones whatever, and no injury to the walls of the chest or respiratory system could be detected, so that it is evident that the fractured ribs could not have in any way contributed to the cause of death, which was, in my opinion, due to the state of the brain. This view was also taken by the jury, who had the advantage of a medical coroner to direct their investigations.

Spinal Sclerosis or Degeneration following Brain-Lesion. By
WM. JULIUS MICKLE, M.D.

This paper deals with a part of the subject only. One of its chief objects is to give examples, occurring in the insane, of spinal sclerosis or degeneration secondary to local encephalic lesions. Another co-ordinate object is to place more fully on record, and exemplify cases forming the links between those thus named and some forms of secondary spinal changes occurring in general paralysis of the insane. But these latter changes, in the form in which they more usually occur in general paralysis, are not dealt with here.

In the following cases, occurring in the insane, only very brief summaries of symptoms and of principal lesions will be attempted.

As far as concerns the cord in the majority of these cases the secondary descending sclerosis, or degeneration, was of *one* lateral column only; in the fourth case it was of *both*, but there was also a diffuse mild sclerosis in all the columns; and in the sixth case, also, these columns were affected on *both* sides. As a rule, the crossed pyramidal tracts were the parts chiefly affected.

With respect to the primary encephalic lesions; in the first case these were of the convolitional surface, extending into the medullary substance, and destroying some of the out-spread radiations of the internal capsule; in the second there was diffuse disease, not of gross character, especially in the fronto-parietal grey cortex; in the third there was local destruction of some of the convolutions, and of part of a corpus striatum; while in the fourth case, with both lateral columns affected, but chiefly the pons and bulb, the primary local destructive lesions were mainly of parts of both the corpora striata. In the fifth case, part of the temporo-sphenoidal lobe and of the subjacent medullary substance was destroyed, the destruction also invading the lower parietal lobule slightly, while part of the corpus striatum of the same side was degenerate. In the sixth case, destructive lesions of the right corpus striatum, and a smaller one of the left corpus striatum and affecting the internal capsule, anomalous or absent pyramidal decussation in the medulla oblongata, a rounded degenerate tract in the left lateral column, a wedge-shaped one in the right. In the seventh case were a central medullary lesion of right hemisphere, at about level of centrum ovale majus, destruction of parts of right corpus striatum and internal capsule and of parts of left caudate nucleus, sclerosis in left lateral column of cord. In the eighth case, a destructive lesion of parts of a corpus striatum and of internal capsule, and of some medullary brain-substance, was associated with degeneration of part of the corresponding crus cerebri. In the ninth case, considerable atrophy of one cerebral hemisphere, with the lesions of general paralysis more pronounced in it than in the other, was followed by degeneration of the lateral spinal column of the opposite side. With reference to some other points, one or two of these cases have been reported elsewhere.

CASE I.—This patient, a soldier, died at the age of 54 years. Mental disease, attributed to sunstroke, had been of more than 12 years' duration, and right hemiplegia and aphasia had coexisted. Paroxysms of excitement, with slight tendency to be violent, destructive, and dirty, came on from time to time.

The tongue could not be voluntarily protruded, paresis affected the right side of the face, and in walking the right leg was raised high from the ground, swung round, and, advancing in a shaky manner, the foot was at last placed awkwardly on the ground with the toes turned outwards. The right upper limb was still more palsied, the elbow being flexed, the forearm semi-pronated, and the fingers rigidly flexed into the palm of the hand. Articulate speech was lost, the utterances

being limited to a few inarticulate, but partly intelligible, sounds and cries. A moderate amount of gesture-language was retained, and the correct names of articles were easily recognised by the patient. Agraphia was present. The palsy was intensified before death, and the gait became slightly hopping, the right arm more rigid.

Abstract of Necropsy.—Several large tracts of the convolutional surface of the left cerebral hemisphere had completely disappeared, leaving behind them only greyish-yellow patches to which the thickened meninges adhered. The parts destroyed included—the whole of the ascending frontal convolution, except a narrow band at its lower end; the ascending parietal, except most of its lower $1\frac{1}{4}$ inch; much of the posterior half of the second frontal; the anterior part of the supra-marginal; the posterior part of the paracentral lobule. The third frontal was destroyed only at its posterior border where it blended with the ascending frontal, and the lesion ceased $\frac{1}{3}$ of an inch behind the perpendicular ramus of the fissura Sylvii; and only the outskirts of the insula were affected.

In the right cerebral hemisphere a similar lesion had destroyed most of the supra-marginal convolution, and part of the middle third of the ascending parietal. Where undestroyed, the grey cortex was atrophied in the anterior regions, especially on the left side. The left basal ganglia were less plump than the right, especially the optic thalamus. The left olfactory bulb and tract were much wasted; the right less. The left cerebral hemisphere weighed $3\frac{2}{3}$ ozs. less than the right.

The left crus cerebri was atrophied, so was the left side of the pons Varolii, a sclerotic patch being seen in its cross-section. Coming to the medulla oblongata, there was grey degeneration and atrophy of the left anterior pyramid, except a few of its outermost fibres. The band of grey degeneration became gradually narrower, below, at the decussation, the grey fibres successively disappearing thereat into the anterior fissure. The grey degeneration was continued downwards in the posterior part of the right lateral column of the spinal cord. There being also *direct* atrophy of the anterior and median part (Türk's) of the left antero-lateral column, but here without very marked induration, or greyiness. Spinal meninges opaque and œdematous; much spinal sub-arachnoid serosity, as also cerebral.

CASE II.—A soldier, died at the age of 37, of well-marked mental disease after two years' duration, which, however, had previously come on in a slow and insidious manner from syphilis. Soon he became aphasic, demented, dirty in habits, restless, destructive. Paresis existed in the right lower limb, sensibility was fair in the hands. Articulate speech was practically in abeyance. Besides an occasional "yes" or "no," a few ejaculations and broken words were uttered, but these were merely exclamatory and quasi-automatic or emotional in character, and were often oaths or monosyllabic obscene expressions. Amnesia, agraphia, and loss of gesture-language co-existed. Finally, the tongue became rather tremulous and jerky, the patient restless at

night, sores readily formed on the limbs, marked tremulousness attended every movement, passive motion was resisted, the knees were drawn upwards, the trunk was bent forwards.

Necropsy.—The olfactory bulbs and tracts were somewhat wasted. The cerebral pia-arachnoid was unduly opaque, and œdematous. The left frontal and parietal grey cortex was much atrophied, pale and firmish; the orbital cortex suffered the most. The cortex of the right hemisphere was less affected. The left insula was softer and more friable than the right, and was slightly reddish. The left cerebral hemisphere was of 1oz. less weight than the right.

On both sides the white cerebral substance was rather pale and firm in the anterior region, so were the corpus callosum, fornix, and white substance about the lateral ventricles, the ependyma of which was rather opaque and firm, but there was no obvious coarse lesion of the basal ganglia. There was, however, sclerosis, apparently of a secondary descending nature, in the posterior part of the right lateral column of the spinal cord, particularly in the upper eight inches of its length. The leuco-myelitis was, however, slightly diffused transversely beyond the limits named.

CASE III.—J. S., a retired manufacturer, died aged 74, after more than 12 years of mental disease, which, beginning as mental inaptitude with melancholia, had for some years before death been of the form of dementia in which extreme mnemonic failure was the predominant feature. With this, however, there were good temper, cleanliness, politeness, and consideration for others.

Twelve months before death left hemiplegia came on suddenly, the seizure being accompanied with some mental confusion, and followed by thick, muffled paralytic speech, but its onset not being associated with any coma or convulsion. After this time the food was apt to collect in, and distend, the left cheek; the left lower limb was increasingly rigid, straight, immovable, with the foot in a talipes equinovarus position; the left upper limb was rigid, acutely flexed at the elbow, with the wrist flexed and abducted, and the fingers tightly flexed into the palm and abducted. There was no ankle-clonus; patellar tendon-reflex was only slight. In the left leg were diminished sensibility or reaction to pinches; in the left arm these were fairly obvious, and in the right limbs perhaps rather too much so. The right leg was usually flexed and abducted. Vision seemed to be impaired or lost towards the right side; the head, too, was sometimes turned to the right, the eyes to the left. Salivary dribbling, urinary incontinence, and dysphagia increased before death, and a sore appeared on the left heel.

Necropsy.—Arteries of brain highly atheromatous. Various parts of the brain had undergone complete destruction, viz.:—(a) the middle part of the right paracentral lobule, with another part of the gyrus marginalis adjoining, and part of the gyrus fornicatus; (b) the middle of the outer part of the caudate nucleus of the right

corpus striatum, extending to the internal capsule; (c) several superficial patches on the upper surface, adjoining the posterior two thirds of the great longitudinal fissure; (d) large destruction on the inferior surface of the left cerebral hemisphere, involving the lobulus lingualis and parts of the fusiform lobule and uncinate or hippocampal gyrus, and extending into the lateral ventricle; (e) the posterior median part of the left optic thalamus; (f) wasting of the middle and posterior part of the right crus cerebri, and of the pons Varolii; (g) a small cavity in mid-depth of the pons, by the right side of its antero-posterior median plane; (h) five patches of destructive change on the under surface of the left lateral hemisphere of the cerebellum. Some sclerosis of the posterior part of the left lateral spinal column, and some wasting of the left posterior grey cornu.

Remarks.—Here the spinal sclerosis, apparently, was secondary to the lesion of the right striate body. The explanation of the diminution of knee-jerk may perhaps lie in the atrophy of the left grey cornu neutralizing the effect of the corresponding lateral sclerosis. The sensory affections in this case were not very readily explicable.

CASE IV.—A soldier died, æt. 38. Being the subject of a separate communication, this case will be only briefly noted here.

Speech was slow, deliberate, at times mumbling, often somewhat explosive. In walking, there were violent convulsive to-and-fro jerks at the knee-joint; the legs were planted convulsively, the heels brought down. Latterly the body was bent backward, the arms were abducted, and the fingers extended and rigid, but only during walking. There were some resemblances to, and differences from, both the ataxic and spastic forms of gait. Patellar tendon-reflex was well marked. There was no ankle-clonus. Some failure of tactile sensibility and much failure of thermic sensibility in the feet also occurred, as well as temporary strabismus.

Necropsy.—Atrophy of the 2nd, 6th, 8th, and 9th pairs of cranial nerves, doubtful slight atrophy of the facial nerve. Some general meningeal thickening, &c. Two destructive lesions of the intra-ventricular part of the left corpus striatum, and one of the right, all extending to the depth of nearly half an inch. General slight wasting of the optic thalami, and a small destroyed patch in the depth of the right one. Bilateral secondary descending sclerosis and atrophy of the pons Varolii and medulla oblongata, so that their anterior surface was shrunken, sunken, and irregular. Atrophy of anterior pillars of oblong medulla, doubtful induration of its posterior columns. Spinal cord pale, unduly firm in all its columns, but perhaps more so in the lateral column. A somewhat diffuse leuco-myelitis, more pronounced laterally.

Here the atrophy was mainly of the pons Varolii and medulla oblongata.

CASE V.—Died, aged 45, nearly seven years after onset of mental disease and paralysis. Before admission he had been successively under treatment for "primary syphilis," dyspepsia, contusion (52 days), chronic rheumatism, and general debility, and then became mentally affected, of wet and dirty habits, and paralysed (on the left side it was stated, though this may have been an error for the right).

Admitted with indications of syphilis. Speech mumbling, thick, indistinct, paralytic; the patient, moreover, scarcely replying, sometimes not at all, or in gibberish, or by a few shaky words or a short sentence. Demented, with but little facial expression. Paresis of right limbs, none of face. Knee-jerks and plantar reflexes present, and knee-jerks, later on, exaggerated, especially the right. Later on, feeble; body bent to left at times, and at times the left leg the more heavily planted; the gait slow, unsafe, jerky; the grasping power of the hands about equal. Later still, long, somewhat heavy and slow but shaky steps, increased knee-jerk, only slight plantar reflex; tactile sensibility fair in hands and feet. Permanent paresis of right limbs. Paralytic and amnesic articulation and speech. During his last short illness the tongue, face, lips, and palate seemed to be considerably paralysed.

Abstract of Necropsy.—Meninges opaque, slightly thickened, oedematous. Slight scattered adhesion and decortication, with some atrophy and pallor of fronto-parietal cortex. Very slight atrophy and fibrous depression on right caudate nucleus. Depressed patch of yellowish degeneration on middle of left caudate nucleus. Yellowish degeneration and destruction of cortex cerebri in and about the left Sylvian fissure, mainly affecting the first temporal, the posterior half of the second, and extending slightly to the supra-marginal and angular gyri, the parts thus affected having for the most part disappeared, but the anterior inch of the temporal lobe being unaffected. The base of the surface-depression of this lesion was covered by thick adherent membranes, and the back part of the lesion coursed beside the middle and posterior horns of the lateral ventricle, at the junction of which these membranes formed the only ventricular covering, in consequence of the extensive destruction of the white medullary substance of the brain. Left cerebral hemisphere two-and-a-half ounces less in weight than the right. Both lateral columns of the spinal cord somewhat sclerosed, there being also a small circle of grey degeneration in the right post-lateral column at its upper end. Traces of hepatic syphilis.

CASE VI.—Died, aged 46; had become mentally affected seven years previously. The history sent with him stated that before admission he had successively been the subject of constitutional syphilis,

and, later on, a "fit," paralysis agitans, paralysis of the left third cranial nerve, right hemiplegia, general psychological and physical deterioration and decadency.

On admission there were traces of old syphilitic affections, and fresh active ones soon occurred. Slight paralysis existed on the right side of the face; incomplete palsy of the right upper limb, most marked in the hand; and an equal degree of palsy in the right lower limb, the foot being carried very clumsily and planted heavily on the floor, and progression being very slow, difficult, and unsafe. In walking the legs were held stiffly, were jerked forward clumsily; the toes first scraped the floor, then were raised, and were set down clumsily on the floor. The right leg was planted heavily, and was not swung round. The feet were kept considerably separated from each other. He complained of numbness and a pricking sensation in the right arm, and both palsied limbs were at times the seat of severe paroxysmal pain. When he stood for a little while the whole body was agitated by spasmodic tremor. Speech was impaired, mumbling and indistinct, with elision of syllables. He was extremely demented and amnesic, utterly unable to give any correct history of his life, and exhibited much emotional weakness, weeping whenever he felt the pain and often when no such cause existed. From time to time he continued to complain of pain in the head and pain in the palsied limbs. Except that the sharp, shooting pains in the limbs greatly abated, the condition did not change materially from that described, and except that the gait was more of a shaky and jerky character.

Abstract of Necropsy.—Venous, passive congestion of brain, some pial oedema of upper and external surfaces, and considerable intracranial serosity. Traces of diffuse external pachymeningitis. Two patches of old destructive softening, one at the middle and one at the junction of the middle and posterior thirds of the intraventricular aspect of the *right* corpus striatum, and both rather nearer the median than the external border. A small patch of similar softening in the mid-depth of the *left* corpus striatum, and affecting the internal capsule.

In cross sections of the spinal cord there was seen a rounded patch of fawn-grey degeneration and softening in the posterior part of the left lateral column, a systematic degeneration or myelitis. Whereas on the right side the posterior part of the lateral column contained a semi-translucent, partly colourless, partly whitish, but gelatinous-looking, wedge-shaped, systematic degeneration coursing through the cord, and, at least in parts, extending to the surface of the column.

Various scars of syphilis; broncho-pneumonia; encysted gall-stone; loaded colon.

In this case, with right hemiplegia, were lesions of both corpora striata. In the right the destructive lesion was double and larger; in the left, though smaller, it invaded the internal capsule. Ordinarily one would attribute the dextral hemiplegia to the lesion of the left striate body in such case, but there was an unusual condition of affairs

in this man's medulla oblongata. No regular decussation of the pyramidal strands could be seen, and instead of it there was a smooth bridge of whitish nervous tissue concealing and obliterating the anterior fissure for a short space, so that, with an apparently anomalous course of the fibres conducting downwards from the internal capsule into the lower pyramidal tracts, there may have been a direct paralysis of the right limbs, from lesion of right corpus striatum, owing to the absence of decussation in the medulla oblongata. In the right side, however, the degeneration was in character not unlike a primary one of the cord.

CASE VII.—Died, aged 67, about nine months after the onset of insanity, as stated. In youth the head had been injured. For two or three years he had been subject to severe bouts of convulsions, in some of which he nearly died. For a week or two before admission he had been restless, noisy, violent, raving.

On admission, he was feeble, emaciated, demented. Afterwards the gait was slow, shaky, feeble, unstable, with feet wide apart, and left foot, especially, planted in a clumsy manner. Later on, long, tottering, jerky, unsafe, shaky steps. Left leg weaker; frequent micturition. Then, great physical and mental improvement. Then, twitching of left upper limb and of left side of face, soon followed by severe epileptiform seizures; and these were succeeded by marked paresis of the left limbs, but not of face or tongue, and by irregular rapid intermittent heart's action, not corresponding to the irregular pulse, and very soon by some excitement, and inflated, expansive style of conversation, culminating in maniacal excitement.

Later on, sudden left hemiplegia, complete in the arm, marked in the face, and moderate in the leg and tongue; numbness and tingling of left arm. After this, persistent severe pains and rigidity affected the palsied limbs, and he was mentally disturbed. Finally, violent, long-continued, sub-intrant convulsions, affecting, in the first convulsion, the left side mainly; but in the later convulsions mainly the right; and accompanied and followed by greater dilatation of the left pupil than of the right. Coma; death.

Abstract of Necropsy.—Old pachymeningitic adhesions to calvaria. Several destructive lesions of brain, where its substance had softened down and disappeared. In the one affecting the right corpus striatum and capsule there was active connective-tissue growth peripherally, with some slight surrounding induration at points, and vascular walls forming the limits of the destructive lesion, while internally the place of the brain-tissue was occupied by connective tissue strands and by *débris*. The parts affected were:—(1) The white substance above the middle horn of the right lateral ventricle and opposite to the end of the Sylvian fissure and first temporal sulcus. (2) External part of right corpus striatum, and internal capsule adjoining, softened and pulpy. (3) Softening of posterior half-inch of left caudate nucleus.

Some sclerosis of left lateral column of spinal cord at its upper

part. Cardiac, aortic, coronary, and some cerebral atheroma ; somewhat granular kidneys.

Here one lesion was both destructive and irritative, and the convulsions were probably purely symptomatic. The rigidity and pains of left limbs were from myelitis, secondary to the right strio-capsular lesion. It was not quite clear why most of the convulsions in the final bout were dextral.

CASE VIII.—Died, aged 55, after insanity of more than 20 years' duration. For many years there was a recurring stoppage in speech, followed by internal effort, and then sudden utterance. Nearly seven years before death he had a sudden attack of paralysis of the right side, and marked impairment of speech, coming on without spasm or loss of consciousness, and he was laid up in bed for a few days. The face and tongue were the parts chiefly paresified, the arm slightly, the leg not decidedly affected.

The speech was soon better again, but there remained an exaggeration of the old condition described above, and with this was connected delusion as to orders from imaginary persons to injure those to whom he spoke. The condition was, perhaps, partly due to a slowness in educating and in bringing into play parts acting in a supplemental or substitutive manner in speech, subsequently to impairment or destruction of other parts.

Abstract of Necropsy.—A destructive lesion, consisting of a confluent pair of patches of softening, disintegration, shrinking and sinking of the outer border of the intra-ventricular part of the left corpus striatum, extending into the white medullary substance, and destroying it nearly as far down as to the grey cortex of the left insula, and extending as far as to affect the upper anterior part of the cerebral peduncle slightly. Below this was a tract of grey degeneration of the inner portion of the crusta or basis of the left crus cerebri. The grey degeneration, however, could not be distinctly traced in the spinal cord.

CASE IX.—A chronic case of general paralysis. Two years before death right hemiplegia with aphasia came on suddenly, but without spasm or loss of consciousness. Afterwards there was some twitching and jerking of the right upper limb, and at times twitches and spasmodic jerks of the right lower limb, which, also, was rigidly stiffened when any passive motion of it was attempted. The knee-jerks were vigorous. Never quite disappearing, the hemiplegic condition recurred at times in marked degree, and on these occasions the speech was much implicated.

Abstract of Necropsy.—Brain flabby, soft. Meninges much opacified and somewhat thick and tough. Much adhesion and decortication, especially of the left cerebral hemisphere, of which the summits of all the frontal gyri were affected (except the upper part and lower edge of the ascending frontal), and all the summit-surface

of the parietal gyri; while the marginal and first occipital gyri, and the posterior fourth part of the temporo-sphenoidal, were considerably affected. Brain much atrophied, especially the left cerebral hemisphere, which weighed $3\frac{1}{2}$ ozs. less than the right. Marked changes of the spinal meninges, of the usual character. Some naked-eye grey degeneration of the posterior part of right lateral column of cord.

In a work on General Paralysis, published in 1880, and on other occasions, I have expressed the view that in general paralysis there is sometimes a systematic sclerosis of cord, or secondary descending systematic myelitis, in an incipient, or nascent, or diffuse form, and secondary to the widespread damage to the brain-cortex, wrought by the lesion of that affection. It may, too, sometimes be secondary to a lesion lower down in the cerebro-spinal axis, and due to a local intensification of the morbid process.

The concluding case in this paper has been inserted as an example of a condition transitional between that of the other cases of the paper and the condition just referred to as often found in general paralysis. It presents an extreme and palpable degree of a condition which in its milder degrees is frequently present.

Dr. G. H. Savage, also, has published several cases of general paralysis with lateral sclerosis.

OCCASIONAL NOTES OF THE QUARTER.

Case of Frederick Marshall.

Much criticism has been offered in the public press on the course pursued in the case of Marshall, alleged to have murdered a girl at Woolwich. He was committed by the magistrates for trial at the Central Criminal Court. When, however, the case came on for hearing, it was found that Marshall had been removed under a warrant of the Home Secretary to the Broadmoor Asylum. The criticism to which we have referred had not only reference to a very minor point—the signing of the warrant of removal by an *Assistant-Under-Secretary* of State, but to the removal of an alleged criminal to the criminal lunatic asylum without a jury having decided that he was unable to plead, or the fact of his guilt having been first established.* In reply to the

* Baron Huddleston has more recently taken occasion, when giving judgment in another case, to observe that the whole subject of the Lunacy Law must be reconsidered, and he gives as an illustration of this that “There is a power in our Criminal Law by which a man charged with the gravest offence may, on the certificates of two justices and two medical men, be withdrawn by the Secretary of State from trial; and this also without open examination of witnesses, and without the ordinary test of cross-examination. No doubt at present there may be no probability that a Secretary of State will abuse such a power. But it is an enormous power to give to any person to remove from trial one who has been committed for trial for a serious offence.”

objections made by Mr. Baron Huddleston to the course pursued, the Attorney-General stated that the power exercised was an old power, created in 1840,* to order the removal of a prisoner before trial, if certified to be insane. In Dr. Orange's Presidential Address in 1883, he gave figures showing that down to the end of 1882 there had been 80 persons admitted into Broadmoor who had been certified to be insane whilst awaiting trial, of whom 48 were charged with the crime of murder.† Ware, to whose case we shall shortly refer, and Oliver who stabbed Lindsay, were both certified to be insane before trial, and so was Mary Ann Thompson, the wife of a railway porter at Colchester who recently killed her child, all these cases occurring in the present year. There is, therefore, nothing in the case of Frederick Marshall which is unprecedented or even unusual. Whether it is proper or desirable that persons alleged to have committed crimes should, on medical certificates, be removed to Broadmoor without any indictment being preferred against them at the assizes, is another question. As a matter of fact we believe that up to the present time, the right course has been pursued, not only in the interests of the patient, but in the interests of Society at large. It is not remarkable, however, that such a procedure fails to meet with the approval of a lawyer who is prepared to prove that his client never committed the act, which it is assumed he did commit when insane. Nor is it surprising that the press should animadvert upon this mode of action. Thus a morning paper writes :—"Magistrates and doctors can be got to sign anything when invited to do so by much less august personages than Secretaries of State. . . . If a man charged with murder is mad, let him be proved to be mad in open Court. Where is the necessity of secrecy? And what if he be innocent of the crime with which he is charged? Then why should Marshall, for instance, be assumed to be guilty if in the eyes of the law he is innocent? Yet he is treated as a criminal lunatic. Guilt and innocence, sanity and insanity, should be treated, not by Secretaries of State, but by judges; and it is to be hoped that the law will be quickly amended so as to make this compulsory, even in the case of assumed lunatics." Another London paper writes in the same strain :—"Marshall may be kept in Broadmoor for the rest of his life, or sent at any time to take his trial, or unconditionally released, just as the Secretary of State pleases, though of course he would neither be tried nor set at liberty unless medical opinion announced him to have recovered his reason. He is classed among criminal lunatics, and yet he has never been found by any competent tribunal to be a criminal, nor after any public enquiry to be a lunatic. He may be innocent of the crime imputed to him. The evidence of his insanity might fail to satisfy a jury. In the former case, a great injustice has been done to him; in the other case, a most atrocious murderer escapes the gallows. Surely this branch, at least, of the Lunacy Laws needs amendment."

* Act 3 & 4 Vict., with the Act 27 & 28 Vict. making it compulsory.

† "Journal of Mental Science," Oct., 1883, page 336.

We confess that we do not share the fears expressed by the newspapers. It is very true, no doubt, that the evidence of a prisoner's insanity might fail to satisfy a jury, but this, from our point of view, is only another way of saying that the jury would not have the knowledge or the judgment necessary to form an opinion, and that the physicians consulted by the Home Secretary would be infinitely more likely to arrive at a correct conclusion. In this, as in other cases, although there may be a seeming want of the publicity which the English Law usually demands, it is practically true that

"Whate'er is best administered, is best."

And as regards publicity, it is certain, at any rate, that there has been as much publicity as in the other cases that have been similarly dealt with. Counsel for the prosecution stated in Court that the certificate upon which the Home Secretary's warrant of removal was granted had been signed by two magistrates and two medical men, in conformity with the statute. He further stated that the prosecution had thought it right to take the statement of a medical man at Woolwich, who had seen the prisoner when he had attempted to commit suicide, and who thought he was not responsible for his actions. Also that two physicians had seen the prisoner on behalf of the prosecution, and that there was only one opinion, namely, that the prisoner was insane.

Mr. Justice Hawkins on the Plea of Insanity in Criminal Cases.

We note with great satisfaction the observations made by one of her Majesty's Judges in his charge to the Grand Jury at the Shropshire Winter Assizes. His remarks had reference to the case of Anthony Ware, charged with murder at the Salop and Montgomery County Asylum, Bicton, near Shrewsbury. After the homicidal act was committed, the patient was removed to Broadmoor. Under these circumstances the finding of a true bill did not come under the consideration of the jury. The Judge, however, regarded the case as so "very interesting" that he went out of his way to comment upon it. It appears that Ware had been for a considerable time a dangerous lunatic. Dr. Strange, the Medical Superintendent of the Bicton Asylum, stated that while he had been a patient at the County Asylum he had committed several murderous assaults upon patients, and in one instance upon an attendant. On the fatal day this homicidal patient had been out for an airing with another dangerous lunatic named Smith; indeed, there seemed to have been some 15 or 16 patients of the class together. On returning to the asylum Ware provided himself with an iron bar from a bedstead, and was seen by the attendant in charge to strike the deceased (Smith) upon the head with it. From the wounds thus received the latter quickly

died. As Ware threatened to murder everyone who approached him, prompt assistance could not be rendered to save Smith's life. It may be observed in passing, that Mr. Justice Hawkins suggested whether it was wise to allow so many dangerous lunatics to be together. We now come to the point in the charge which has induced us to call attention to the observations of Sir Henry Hawkins. He is struck with the very unsatisfactory state of the law in respect to the responsibility of criminal lunatics. He does not hesitate to acknowledge that the rules by which the Judges are guided, and upon which they consider it right to act so as to get uniformity of practice and law upon the subject, fail to meet such cases as Ware's. Having called attention to the answers given by the Judges to certain questions propounded to them at the trial of McNaghten, his Lordship said, what is so well known to our readers, that to establish the plea of insanity "it must be clearly proved that at the time of the committal of the act the accused was labouring under such a defect of reason or disease of mind as not to know the nature of the act he was doing, or that he was doing what was wrong." His Lordship then requested the jury to apply this test to the case in question, in which no one, lawyer or layman, would venture to say that this wretched man was responsible for the act which he committed. Yet, although he was a confirmed lunatic, he was perfectly aware, according to the depositions, of the nature of the act. It was quite clear, from what he himself had said, that he had killed someone, and that he was also aware that what he had done was wrong, for he extracted a promise from Phillips that he should not be punished if he gave up the iron bar that he had in his possession. "*This being so, it would be impossible to say that Ware did not know that he had killed a man, because he said himself that he had, and it would be impossible for anybody to urge that he did not know it was wrong, for he wanted a promise that he should not be punished, but unless one put a totally different construction on the law, that would have to be proved, although no man in his senses would suppose that any jury would find Ware responsible for what he had done.*"

This proves conclusively that Mr. Justice Hawkins understands the law laid down by the Judges in the ordinary and obvious sense in which it is generally understood, namely, that in order to acquit a prisoner on the ground of insanity it must be shown that he did not know the act, judged by the laws of his country to be wrong, in consequence of mental disease. The other sense in which this test may be interpreted is this—that the accused did not believe, in consequence of his mental condition, that the act was wrong in him, but, on the contrary, right. If this interpretation, which was very possibly the meaning attached to it by the Judges at McNaghten's trial, were really adopted by our Judges, the evil wrought would be much less than it is, and, indeed, it would hold good in the majority of cases, even in those in which a man knows that the homicidal act he commits is not only

legally wrong, but committed without provocation, and therefore wrong in him but for the fact that he felt himself utterly unable to prevent himself doing it. Sir Henry Hawkins obviously does not see the matter in this light, nor, as we pointed out in the case of "*Regina v. Cole*," was there during that trial any indication of such a reading of the law as this. We can therefore only continue to urge a change in the present mode of expressing the legal test of criminal responsibility, and we must rejoice that so luminous and outspoken an utterance should have proceeded from the Bench, one so entirely in accordance with the remonstrances of mental physicians who have written on the plea of insanity in criminal cases. We are glad also to find his Lordship making the observation that "he had not spoken only his own views upon the matter, for more than one of the Judges had expressed the desire that the law upon the subject should be revised and a little more definite understanding arrived at." This augurs well for the future recognition of correct views on this important subject on the part of the lawyers and the legislature.

Action Against the Lewes Magistrates.

A very unusual application was made on the 9th of February in the High Court of Justice, before Mr. Justice Grove and Baron Huddleston. Sir H. Giffard moved for a rule *nisi* for a writ of *certiorari* to bring up an order of two Justices of Sussex, directing the conveyance to the County Lunatic Asylum of a Mr. Hillman, in order that it might be quashed. It appears that this gentleman, who resides at Lewes, is of independent means. One day, when about to sit down to dinner, the parish constable called at his house with the order of the Justices. Mr. Hillman declined to open the door, and it was consequently broken open, Mr. Hillman being removed from his house to the Haywards Heath Asylum. He was transferred thence to St. Luke's Hospital, where he was examined by the Commissioners in Lunacy, and immediately discharged.

As under Jarvis's Act there is a provision that when an order has been made against anyone by the Justices it must be quashed before an action can be commenced against them, Sir H. Giffard made the above application. It was not suggested that the Lewes Justices were actuated by improper motives, the contention by Mr. Hillman being that the proceedings were taken with a malicious object by persons employing the Justices to carry out the scheme. It was urged, however, that the Justices had disregarded every provision of the Lunacy Act. Mr. Hillman had not been brought as a wandering lunatic before the Justices. A medical man had not been called to their assistance; and, above all, the Justices had not themselves, as directed by the Act, properly examined the alleged lunatic in order to ascertain whether he was a fit person to be sent to an asylum.

It was alleged that on the 24th of November last, Mr. Hillman, when at the Fitzroy Library, Lewes, was accosted by a Dr. Crosskey, who, however, in no way examined him. Further, that the two Justices referred to only saw Mr. Hillman on the same occasion through a glass door in the Library. Mr. Justice Grove observed that it would be a very strained opinion to suppose that the "examination" required by the Act meant looking through a glass door. He thought that it was too improbable to have occurred. Baron Huddleston, while agreeing with Mr Justice Grove, said he had found in many instances that Justices signed their orders with the greatest carelessness. "I am afraid too much laxity is introduced into these matters," said his Lordship.

The rule *nisi* was granted by the Court.

If the above statements are substantiated, they are a striking illustration of the perfunctory manner in which Magistrates fulfil the duties with which they are charged in regard to the examination of lunatics prior to their removal to the County Asylum. It is peculiarly important at the present time to realize how slight a safeguard magisterial examination forms against the improper admission of patients into asylums, seeing that an attempt is being made to require examination by a Justice, in every case, whether private or public, before confinement in an Institution for the Insane. It may satisfy the public demand for fresh restrictions, but it would be delusive, and would, therefore, be mischievous, like the Sheriff's Order in Scotland, in leading people to suppose that the guardianship of the liberties of the insane is secured by being left in the hands of these personages.

Since the above was in type, it has been ruled by Mr. Justice Grove and Mr. Baron Huddleston that the action of the Magistrates in this case was illegal on the ground that the removal of Mr. Hillman to the asylum was made without proper personal examination, this only having been made after his seizure, and while the complainant was in the carriage on his way to the asylum. The judgment turned upon the interpretation of the 68th sec. of 16 and 17 Vic., chap. 97. It appears that shortly after the Magistrates left the library they were informed that he was in a carriage close by, and to this they went, and had four or five minutes' conversation with him. He was then taken to the asylum, and they proceeded to make their order for his removal, appending the medical certificate. Mr. Justice Grove came to the conclusion that the above examination did not fulfil the requirements of the statute. He held that it was intended that an alleged lunatic should be brought before the Magistrates, and that there must be a joint examination by them and the medical man. If the examination of the Lewes Magistrates were within the meaning of the statute, it might lead, he held, to the most flagrant abuse and the most formidable consequences.

Mr. Baron Huddleston, after severely criticising the laxity of the Lunacy Laws in regard to private patients, observed that in the

enactment in question the Legislature have endeavoured by every species of safeguard to prevent the liberty of those to whom it refers being improperly interfered with; and yet, he proceeded to say, it is remarkable that almost every one of these safeguards had been neglected in the present case. It is a startling fact also that the Clerk to the Magistrates stated that it had been his practice for 17 years to make lunacy orders in this way.

"First," said his Lordship, "there is to be an 'information' upon oath, but there was none here before the proceedings commenced. The Relieving Officer, made an 'information,' but that was after the medical man made his certificate and after the Magistrates had come to their conclusion, and after the alleged lunatic had been taken to the asylum; then it was that for the first time the Magistrates had an 'information.' The Relieving Officer arranged with Dr. Crosskey to give the certificate, and had arranged with the Magistrates to go and meet him at the library, and then it was that the Magistrates saw Hillman through a glass door, and then, without any authority, the policeman went with another man to Mr. Hillman's lodgings, where he had locked his door, and, being refused admittance, broke open the door with the assistance of a blacksmith, and conveyed him away to the asylum. No order, no examination, no information on oath; nothing but the medical certificate. That was the way in which the provisions of the Statute for the protection of alleged lunatics were carried out. The medical man made his examination without any authority. 'Somebody' sent the policeman with the blacksmith to the house to break open the door and take him away. 'Somebody' had hired a carriage to take him. 'Somebody' had caused this to be done without any order, or any previous inquiry, or any personal examination. I cannot believe for a moment that they could justifiably, without any evidence, find that the complainant was a 'person proper to be detained under care and treatment,' they themselves finding that he was not dangerous to himself or others; and the only thing put forward in the affidavits being, that somebody says that his landlady says that he had thrown open his window—a really ludicrous thing to suggest as an indication of insanity. I am of opinion that the Justices had no jurisdiction to make the order; and that the writ of *certiorari* must issue to bring it before the Court that it may set it aside. I regret the result, because the Magistrates had no bad motive, but if the Legislature has made certain provisions for the protection of the public, it is our duty to see that they are not disregarded."

It is evident from what transpired in Court, as well as from the experience of County Asylum superintendents, that the Lewes Magistrates are not sinners above all other Magistrates because they suffer such things, and will suffer, we doubt not, much more. A lax custom has grown up, and it is high time that either the law should be modified or that the Magistrates should be obliged to perform their duties according to the requirements of the Statutes. To this end the judgment delivered by the Judges will, no doubt, largely contribute. Magistrates will now be obliged, no less than medical men, to be extremely careful how they infringe the Lunacy Acts, and subject themselves to actions at law, involving them in blame, anxiety, and expense. Judges do well to enforce the law.

Lowe v. Fox.

We are glad to see from the papers that Mrs. Lowe has failed in her action against Dr. Charles H. Fox of Brislington House. The case came on for trial during the winter assize at Taunton, on 22nd January, 1885, before Mr. Baron Pollock and a special jury.

The plaintiff, Mrs. Louisa Lowe, claimed damages against Dr. Fox for having maliciously, and without reasonable and probable cause, assaulted and imprisoned her on the 27th September, 1870, and having detained her until the 15th February, 1871.

The defendant denied the alleged assault and imprisonment, and pleaded—(1) That at the time of the alleged assault and imprisonment he was simply a salaried medical officer, and superintendent of Brislington House Asylum; (2) That the plaintiff was admitted by the proprietor of the asylum into Brislington House, which was a duly licensed asylum, under an order for her reception by her husband, accompanied by medical certificates, as required by the Lunacy Statutes; and (3) That, by sec. 99 of the Lunacy Act, 1845, a proper order of admission, accompanied by the required medical certificate, is sufficient to protect a licensed asylum proprietor in receiving patients; that, by sec. 105 of that Act, any action or suit brought against any person for anything done in pursuance of that Act, shall be commenced within 12 months of the release of the party bringing it; and that, by the statute 21 Jas. I., c. 16, sec. 3, all actions of *inter alia*, assault and imprisonment, shall be brought within four years next after the cause of such action or suit, and not after.

Before the action came into Court, it was admitted, on behalf of the defendant, that, subsequently to Mrs. Lowe's admission to the asylum, the answer to the question "when and where previously under care and treatment," contained in the statement attached to the order of admission, was altered by the addition of the words, "for hysteria, by Dr. Conolly, Hanwell, Dr. Mackintosh, Torquay, and Dr. Mannoir, Geneva, &c."

The answer originally stood, "during this period of 20 years has been constantly under treatment." It was also admitted that the copy of the order of admission sent to the Commissioners in Lunacy, within the time required by the statute, did not contain the before-mentioned addition, and that no copy containing such addition was ever sent to them.

On behalf of the plaintiff, it was argued by Mr. Bassett Hopkins that the order of admission was irregular and invalid. The order of admission, he said, was not a "proper order," and, therefore, the receiving and detaining of the plaintiff in his asylum was a trespass, and the defendant could not rely upon the 99th section of the Lunacy Act of 1845 (8 and 9 Vic., c. 100) as a defence to the action.

Mr. Hopkins also contended that hysteria was not insanity, and that the order of admission was also on that ground defective.

After Mrs. Lowe had given her evidence in chief, it was submitted, on behalf of Dr. Fox, that the order of admission was a proper one.

Baron Pollock, in giving judgment of nonsuit against the plaintiff, held that the order was a proper one. His Lordship said that the three particulars in the statement, (1.) Whether first attack? (2.) When and where previously under care and treatment? (3.) Duration of existing attack? should be answered to the best of the knowledge and information of the person signing it; and, in testing the propriety of the answers, these three heads of particulars should be read together: further, that, so far as the evidence went, there was nothing to show that Mrs. Lowe's husband, who signed the order of admission and the statement appended to it, had not given, *bonâ-fide*, the best answers within his knowledge: that it was clear that the medical certificates of the certifying doctors, which were also appended to the order of admission, were, together with the order of admission, a justification for the reception and detention, by Dr. Fox, of Mrs. Lowe; and that Dr. Fox was, therefore, entitled to succeed in the action. Other questions immaterial to this report were also decided in favour of Dr. Fox. The case is now on appeal, when the law on the subject will, it is hoped, be finally settled, as the cases on the subject are by no means consistent, the better opinion being, apparently, that if the person signing the statement does so *bonâ-fide*, the Court will not look too closely to the exact sufficiency of the answers. Otherwise it must be admitted that no inconsiderable number of patients are at the present time in confinement with "Statements" which would by no means bear very critical examination.

Recent Researches into the Functions of the Mesial Surface of the Cerebral Hemispheres.

In the "Proceedings of the Royal Society," No. 231, 1884, is a communication by Professors E. A. Schäfer, F.R.S., and Victor Horsley, F.R.C.S., on the "Function of the Mesial Surface of the Marginal Convolution" (including, of course, the paracentral lobule of Betz), which calls for notice in the pages of this Journal. The uppermost or marginal convolution on the mesial surface of the cerebral hemisphere is really the side of the superior frontal gyrus, and is also the side of the anterior half of the parietal lobule, since it is limited below by the callosomarginal sulcus, which terminates posteriorly by turning upwards towards the upper margin of the mesial surface at a point about opposite the middle of the parietal lobule.

Thus we should regard this mesial portion of the cortex cerebri as really belonging to the excito-motor region, but up to the time of the

above communication it has not received successful attention at the hands of physiologists.

Before describing the function of this marginal convolution it may be as well to state that the paracentral lobule, situated opposite the upper end of the fissure of Rolando and the ascending frontal gyrus, while really part of the marginal convolution, and therefore already part of the excito-motor area of the cortex, has been shown by Betz to be particularly rich in giant motor pyramidal corpuscles; more so in fact than many parts of the excito-motor region, and later it will be shown that this is really the centre for most important movements of the lower limb. Moreover that, according to Messrs. Schäfer and Horsley, stimulation of the rest of the cortex of the mesial surface is without effect. These observers do not find that the whole of the marginal convolution is excitable; far from it, they show that a line drawn at right angles to the great median fissure, so as to limit the extent of the excito-motor area on the upper and outer convex surface of the hemisphere, also limits the front of the excitable portion of the marginal convolution, so that the excitable portion of the marginal convolution is confined to about its posterior three-fifths. Ferrier had shown that in the excitable portion of the gyri of the outer convex surface of the hemisphere, there are centres regulating the movement, of the muscles of the face and limbs, but none causing movements of the trunk except the rotators of the head. Messrs. Schäfer and Horsley's observations fill up this gap by showing that the centres for the trunk muscles are situated in the marginal convolution, so that the list of cortical centres is now complete. These centres for the trunk muscles they find arranged in the cortex of the marginal convolution, following a very definite order from before backwards. At the front end of the excitable portion of the marginal gyrus (which anterior limit we may say happens to be opposite the upper face of the anterior extremity or rostrum of the corpus callosum) are situated centres for flexion and extension of the elbow in the most anterior portion, and centres for movements of the humerus and scapula next behind.

Close behind the centres for the shoulder we find that for the upper half of the trunk, namely, arching of the spine in the dorsal region and rotation to the opposite side; while still further back lies the centre for the lumbar region of the spine, which moves similarly, without, of course, much rotation. In this way the anterior two-thirds of the excitable area is occupied in the very definite order named by centres for the trunk muscles of the upper limb and dorsal and lumbar spine.

The posterior third of the gyrus (or the paracentral lobule) is the seat of the following centres, passing backwards from just behind the centre for the lumbar spine: first, for the gluteal and other hip muscles, next for the hamstrings, &c.; then for the leg muscles; and lastly, for the movements of the foot and toes.

Thus there is a complete sequence from before backwards of the centres in accordance with the anatomical arrangement of the muscles they supply.

The centre for the movements of the leg is thus shown to be extensively situated in the mesial surface of the hemisphere, and Messrs. Schäfer and Horsley do not find that it reaches quite so far back into the outer surface of the parietal lobule as described by Ferrier.

The results just described were obtained by stimulating the surface of the marginal gyrus, with very weak induced currents applied by small electrodes insulated up to the points and inserted between the large veins, so that with a little management of the operative details, the experiment was performed without the least interference with the circulation in the cortex anywhere.

Further they were completely confirmed by antiseptic excision of the marginal gyrus when corresponding paralysis was found to be present in the above-mentioned groups of muscles, and further, on microscopic examination, the usual descending degeneration was traced to the end of the spinal cord.

In the "*Lancet*" for July 5th, 1884, Mr. Victor Horsley publishes some original views on the subject of the possible power of substitution of function by the centres of the central nervous system, and refers especially to Dr. Broadbent's well-known theory that the impulses descending from the uninjured hemisphere (in hemiplegia, &c.) will pass to the muscles of the same side (*i.e.*, the paralysed) by crossing the commissures in the spinal cord. In this way, of course, Dr. Broadbent accounts for the early recovery of the trunk muscles in hemiplegic convalescence, and also the amelioration of the leg paralysis before that of the arm, since it may be assumed, according to him, that the spinal centres for these parts of the body are more perfectly connected by commissural junctions than others, such as those of the arms, &c. Without discussing at length the probability of such rich commissural junction, the existence of which Mr. Horsley is not prepared to admit fully, and against which he adduces reasonable evidence, he proceeds to show in the light of experimental knowledge of the cortical centres that the recovery of the trunk before the leg, the leg before the arm, and occasionally the face before the arm, can be perfectly and easily explained without resorting to hypothesis at all. In the first place it is to be remembered that the "artery of hæmorrhage" (Charcot and Duret), rupture of which usually produces hemiplegia, is situated just below the outer zone of the lenticular nucleus of the corpus striatum, and that consequently hæmorrhage in this situation will push upwards and inwards. But Mr. Horsley points out that the motor centres are arranged in the order from below upwards of face, arm, leg, and trunk, so that the direct pyramidal fibres which lead down from these centres into the corona radiata and then into the internal capsule will be broken

through or pressed upon by the hæmorrhage according to that order. Now this is exactly the order in which the symptoms advance as may be observed in an acute hemiplegia. When recovery takes place, he shows that it does so by reason of the blood clot shrinking and becoming absorbed, and that therefore the pressure will be taken off the fibres in the *reverse* order, namely, trunk, leg, arm, and face. But this again is exactly the order observed clinically in recovering hemiplegics. Consequently he believes that here we have the real explanation of recovery of these groups of muscles. There is another point still, namely, the probability of the trunk muscles being bilaterally represented in each hemisphere; this is, of course, the case with the lower group of facial muscles, and possibly is so with some of the trunk muscles. At any rate it readily explains the occasional early recovery of the face, and may also partly explain the recovery of the trunk, but the main reason he believes to be the anatomico-pathological one given above.

PART II.—REVIEWS.

An Introduction to the Study of the Diseases of the Nervous System, being Lectures delivered in the University of Edinburgh during the Tercentenary Year. By THOMAS GRAINGER STEWART, M.D., Professor of the Practice of Physic and of Clinical Medicine, University of Edinburgh, &c. Edinburgh: Bell and Bradfute, 1884.

Clinical Lectures on Important Subjects: On Giddiness. By T. GRAINGER STEWART, M.D., &c. Edinburgh: Bell and Bradfute, 1884.

It is pleasant now-a-days to meet with a physician who considers the whole of medicine to be his province, who does not wish, and who is not compelled by the exigencies of his position to aim at a reputation for skill in one class of diseases, or the diseases of a single organ. The contributions of the learned Professor of Medicine in the University of Edinburgh show that his attention is not apt to be confined to any one department of medicine. In his three Lectures on Giddiness, published last year, Dr. Grainger Stewart described one particular symptom, and showed the various conditions and diseases indicated and associated with this perversion of sensation. This was certainly a happy idea well carried out, though it would probably not be easy to go

on treating many other symptoms separated from special diseases in so instructive a way. In his *Lectures on the Nervous System*, which is an octavo volume of about 250 pages, Dr. Stewart shows a happy ease of expression and lucidity of style. This is mainly owing to a thorough mastery of the subject, and a pervading clearness of thought. Everything has been carefully studied, thought out, and put into such a form of words as, on repeated trials, has been found best to convey the meaning. In every subject which he discusses the author has gone to the original sources to gain the fullest information, and the knowledge thus acquired is increased and matured by his own clinical experience. When one considers how little of the information contained in these lectures was known ten or twelve years ago, save in a confused and imperfect form, one sees how great has been the progress made in the physiology and pathology of the nervous system.

In the three first lectures he gives a sketch of the medical anatomy of the nervous system; in the next three he considers the significance of the various derangements of the sensory functions. A good portion of this space is given to the eye symptoms in nervous disease, the methods of testing the power and area of vision, hemianopsia, colour blindness, defects in the apparatus of vision and optic neuritis atrophy.

The next two lectures are devoted to the consideration of disorders of the motor functions. Lecture IX. gives a very instructive account of the application of electricity in diagnosis. In Lecture X. he discusses the changes observed in the course of nervous disease in the vaso-motor, secretory, and trophic functions, such as the tache cerebrale, nervous oedema, glossy skin, infantile paralysis and hemiatrophia. The two next chapters are given to the consideration of perversion of the cerebral and mental functions, and to impairment of language. The succeeding one is principally upon the vascular supply of the brain and membranes as influencing diseased action in particular areas.

The concluding chapter on the General Treatment of Nervous Diseases cannot fail to be read with interest. We regret that it is so short. Dr. Stewart certainly indicates in a judicious way the broad lines of treatment, showing himself willing to adopt remedies of every character; but what we should have liked would have been for him to have filled in the finer shadings of therapeutics which his study and experience have taught him so nicely to appreciate. In

this way it would have been an improvement had he filled twenty-eight pages instead of fourteen.

The illustrations, ninety-eight in number, add much to the clearness of the book. They are of all kinds, diagrams and woodcuts in the text, and coloured lithographs, some of which are finely executed. They illustrate points in the anatomy of the nervous system, perimetric records and ophthalmoscopic appearances, diseased conditions, therapeutic apparatus and other things easiest learned by the eye. Altogether Dr. Stewart's book forms a pleasing introduction to the Diseases of the Nervous System. It contains many things which a medical man ought to remember, and reminds him of many things he is apt to forget.

On Sclerosis of the Spinal Cord. By JULIUS ALTHAUS, M.D., M.R.C.P., Senior Physician to the Hospital for Epilepsy and Paralysis, Regent's Park. London: Longmans and Co., 1885.

As we pass up the scale of life from the simplest to the most complex organisms, we review in succession the stages by which, from the simplest ency and motility of the apparently homogeneous protoplasm, we ascend to the highest degree of elaboration of nervous and muscular systems such as we observe in man. These stages, following Spencer, comprise first, the genesis of nerves, then of simple nerve systems, then of compound nerve systems, and then of doubly compound nerve systems. These are not mere words, but terms necessary to the description of a growing complexity in the correlation of parts and, note it well, of nothing more than a growing complexity; for between the first and last terms of the series we have difference in degree, and in degree only—the promise and potency of the first will be found fulfilled in the last. But if this is so, then the natural order of study, both in anatomy and physiology, will be from an examination of the structure and functions of the simple to that of the structure and functions of the complex. We shall ascend from the nerve to the cord—from the cord to the brain. What holds for anatomy and physiology will equally hold for morbid anatomy and morbid physiology (pathology); in the pathology of the simpler structure will lie the promise of the pathology of the more complex structure. It is on this plea we would introduce here into a journal of mental science a treatise on morbid conditions of the spinal cord.

From among morbid affections of the spinal cord, Dr. Althaus has chosen the sclerosis—a group of the greatest importance, and to the understanding of which as much patient attention is requisite on the part of the student as there is needed on the part of the teacher, care in the method of expounding. The author has not, however, bestowed equal attention upon all forms of sclerosis, but, designedly, has singled out that disease which clinically we know as locomotor ataxy for very special consideration—indeed so much so that the work almost stands as a treatise on locomotor ataxy.

In the first, introductory, chapter we start with the definition of sclerosis, which is as follows: “An irritant morbid process, standing intermediate between inflammation and simple atrophy, which invades certain well-defined and evolutionally, anatomically and physiologically distinct areas or systems of that organ; and which leads in course of time to disintegration and wasting of the nerve-tubes, very generally to partial or complete destruction of the axis cylinders, and to over-growth of connective tissue.” The definition is, we think, faulty; first as being somewhat obscure, and secondly in not covering the ground completely. The obscurity lies in the description of an irritant process as standing intermediate between inflammation and simple atrophy. Is this possible? Does not the term irritant imply irritability—imply reaction—and must we not label “inflammatory” that reaction which has resulted from a process which we name irritant? It may be answered that this is not necessary, since we have no certain proof on other grounds that all sclerosis are inflammatory. That is quite possible; but then have we any evidence that such sclerosis are the result of irritation? The question for decision is simply this, Is the term *irritant* applicable if *inflammatory* be not? We put this forward tentatively. The second ground for objection is on the score of incompleteness; for if the term sclerosis be limited to such processes as invade distinct systems of the cord, where will insular or disseminated sclerosis find a place? or, indeed, Charcot’s amyotrophic lateral sclerosis, in which we have simultaneous affection of the lateral columns of the cord and of the large ganglionic cells of the anterior cornua? Moreover, is there not evidence of sclerosis starting in one system, but in the end transgressing the limits of this system? Does it in so doing cease to be sclerosis of the spinal cord? The question, indeed, arises:

Do we need any special definition for *sclerosis* arising in the spinal cord? Does it differ from sclerosis as we are familiar with it elsewhere?

With Chapter II. we enter upon the consideration of the morbid anatomy of *tabes dorsalis*. Here we meet with the more recent views of Strümpell as to the parts first affected in *tabes*, which contrast with those hitherto held. The modification is, however, as Dr. Althaus points out, not in the direction of simplification, but very much the reverse. It is in this chapter that Charcot's arthropathies find mention; and concerning these it would have been perhaps well if Dr. Althaus had pointed out that the very question of their existence as part features of *tabes* is, in this country at least, *sub judice*—i.e., the question is still undetermined as to whether the joint affections, which are undoubtedly met with in locomotor ataxy, present any features by which they may be distinguished from the joint conditions found in rheumatoid arthritis. Certainly the view is not an irrational one, that the two diseases may coexist, the one supervening upon or arising in the presence of the other, just as the lesions of Rickets may appear in the congenitally syphilitic.

Chapter III. takes up the morbid anatomy of other forms of sclerosis, and sets forth clearly the facts as at present held. Upon this follows a very interesting chapter on the etiology of sclerosis generally. The effects of certain well-known poisons here find mention, viz., the production not only of the symptoms, but also of the cord lesions of *tabes* by the continued use as food of bread contaminated with ergot of rye; also the development of symptoms of spastic spinal paralysis as the result of the eating of bread containing the meal of a pulse, the *Lathyrus Cicera*, or lesser chick-pea. Dr. Althaus leads up from these facts to the influence of another poison "which is far more subtle in its nature," viz., the poison of syphilis; and he insists strongly on the etiological relationship of syphilis and *tabes*. A number of cases are given in illustration of this point, and the several objections to the syphilitic theory are well met.

The Symptoms of *Tabes* follow in a very lengthy chapter. Certainly the array here is quite appalling, and not indeed encouraging to the student. We should fear that the effects of the reading of this chapter will be, not that *tabes* will escape recognition, but that *tabes* will be discovered everywhere. From this chapter it will be well if we turn back to p. 50 in the book, and read there that "the

anatomical as well as clinical features of tabes are of an extremely complex character; that they vary greatly in different cases; and that the mode in which they are grouped together has, as yet, not been found to follow a definite law." Indeed, one cannot help feeling and hoping that when tabes shall have revealed itself completely, very many of the symptoms of the pre-ataxic stage enumerated here and elsewhere will have fallen away as mere coincidences—accidents in the case. Meanwhile there is nothing for it at present but to accept the long list as it now stands. The chapter on diagnosis is perhaps a little scanty, but we may take some comfort from it, for we there see that however great the multiplicity of symptoms which may make us suspect tabes, the symptoms on which we diagnose tabes are few and well defined, and they comprise the absence of knee-jerk (Westphal's symptom), the reflex rigidity of the pupil (Argyll-Robertson's symptom), and, in the first part of the ataxic stage, the effect of the removal of the aid of the sight in developing the ataxia (Romberg's symptom). We might add the lightning pains, but these are not crucial in the same way as those just mentioned are.

In the chapter on the Symptoms of Tabes Dr. Althaus makes use of the term "muscular madness" to describe the condition of the third stage of the disease in which "muscular action, as far as it still exists, is in absolute confusion." Also on p. 230 he speaks of the patient "stammering with his feet"—this *à propos* of Romberg's symptom. We quote these two expressions because we think they are happy expressions, and because they bring to one's mind the possible analogy between inco-ordinate movements and inco-ordinate ideas. The anatomical basis of this inco-ordination of movement we have before us in the shape of an interstitial overgrowth of fibroid tissue affecting certain tracts of the spinal cord, and with this interstitial overgrowth atrophy, more or less complete, of the nerve-fibres of those same tracts. The moral is to search for a similar anatomical basis underlying the phenomena of mental inco-ordination; but the moral does not rest there, but points with warning finger to the complexity of symptoms surrounding the lesion in a part—the cord—whose functions are certainly simpler than those of the cortex cerebri. If here we meet, among the presenting symptoms, with confusion, what may we expect to meet with there? Chaos—and for long time to come.

Concluding chapters follow on the other forms of sclerosis clinically considered, but we are unable to enter upon a consideration of these now; and with this very cursory notice, which by no means does justice to the careful criticism which such a work demands, we must end.

H. S.

Comparative Physiology and Psychology. By S. V. CLEVENGER, M.D. 247 pp. 1885.

Few things can be more interesting to the student of sociology than the gradual acquisition of perfect liberty of thought by scientific inquirers, and although the Mediæval ban of excommunication or threats of the stake have lost for three centuries their inhibitory influence, we all know that at the present time there is a lingering notion in many minds (not merely among extreme religionists), that anyone who seeks to explain certain mental phenomena by the facts of anatomy and physiology, is to be regarded as one practising the "black art," and therefore to be treated with caution. That great philosopher, David Hartley (the friend of Newton), when he gave to the world, in the last century, his splendid thoughts on Association, felt constrained to explain most elaborately to his readers that his ideas were not to be supposed in any way to be subversive of the prevailing religious ideas, and the same excusing paragraphs are to be found in psychological works* even as late as 1844. Fortunately the rapid spread of education in the last two decades has removed to a large extent that superstitious ignorance of truth which feared for the safety of justly cherished ideas if they were exposed to searching criticism supported by a more accurate knowledge of psychical, or, in other words, spiritual phenomena, and thus it happens that many persons whose perfect orthodoxy is unquestioned are now ready to hear and discuss such "ultra physical" views of psychology as are put forward in the above work, which it has been our pleasant duty to read. Many of Dr. Clevenger's views have already been published in scientific journals, but we shall make no excuse for referring to these in giving a general survey of the means by which he has arrived at certain striking conclusions, especially as these same ideas, lying buried in magazines, have not apparently,

* Wigan on "The Duality of the Mind."

as indeed he himself somewhat querulously observes, received general notice,

Although, as we have just hinted, our author prepares the way for his explanation of mental phenomena by stating in terms of physical science all motives to action, or, in other words, all "causes," he has hesitated to suggest reforms in the terminology of mental science, which reforms are necessarily sequential to the adoption of his views.

Thus, for instance, although the so-called *meta*-physical method fares badly at his hands on one or two occasions, we must confess to feeling a certain disappointment at not finding offered to us new terms for the old which have been thrown away. Indeed, he has largely employed metaphysical modes (involving huge assumptions) to express views of diametrically opposite tendencies. Especially is this the case when the much-vexed question of "Volition" is referred to, for while in a few words, which repeat the (customary) description of the habits of an amœba, its actions are easily explained to be simple contractile responses to the irritation of *extrinsic* causes or molecular attractions, to our surprise, he at once (p. 7) postulates the assumption that "these" (locomotory and prehensory) "*phenomena in man* and the higher intermediate metazoa are due immediately to *intrinsic* forces, as a rule preponderating over the *extrinsic*, but nevertheless the *extrinsic* remain the remote causes of motion in all animals." What are these "*intrinsic forces*?" We learn nothing from what follows in the next 200 pages, until we arrive at our author's definitive conclusions respecting what he calls (p. 234) "*derived activities, mainly mental!*" Among this class so curiously entitled we find "Volition," and are then still more surprised to learn that it is the "end of deliberation, thought, &c. . . and merges into the purely reflex at one end of the scale, to the relatively free will of the individual with the best brain organisation," we suppose at the other end. In any case, although our author retains the term "Volition," and speaks as above of *intrinsic* causes which are so strong as to "*preponderate*" over *extrinsic* ones, he nevertheless is evidently not at all prepared to accept the doctrine of Free Will; that is to say, he, with many others, cannot admit the causation of the most complex movements to be the action of an *intrinsic* immaterial entity upon the cortical excito-motor area. On this point we should mention that he admits "*all impressions (to) have an objective origin,*"

and again that even thought is "an effect of a chain of antecedent extrinsic causes." It is by phrases such as these we have quoted that he apparently rides with the Rationalistic hounds, and yet at the same time endeavours to run with the Metaphysical fox. We do not wish to be misunderstood, since our only object is to show that, by using faulty terms, ambiguity of meaning necessarily results, and yet the ultimate meaning and intention of the whole treatise is, so far as we can gather, a protest against the idea fathered by the old school of physiology, that mental phenomena are a series of changes comparable to some forms of physical energy, but operating without the existence of matter except occasionally by inconceivable relations with the latter as when movements of muscles occur.

While referring to the older views concerning the so-called processes of the mind, a very obvious but none the less valuable re-statement of what should be the scientific view taken of the unknown relations between structure and function, occurs in the introduction, viz., that while ready to acknowledge the illimitable extent of our ignorance, we exercise neither right nor sense in saying that certain conceivable conditions will for ever remain "unknowable." Yet this is a point of belief which is indulged in at times by some of the most advanced thinkers, who are, perhaps, apt to forget that "nature" reveals herself in many ways, and with as yet unknown laws, and at the same time that the brilliant methods of deduction and induction are neither of them infallible in many hands. Leaving the *quæstio vexata* of the schools to examine more in detail Dr. Clevenger's comparative physiology and psychology, we find a great deal more of the former than of the latter throughout his pages of very ingenious if wordy explanations. Indeed the highest mental processes are simply discussed in two chapters near the end, where each form of mental activity is taken separately, and a few remarks made upon it. We do not notice anything original in these remarks, save the amplification of the author's well reasoned out theory which connects the sensations of Love and Hunger, an idea which deserves close attention from those who are not familiar with it. However, to say there is nothing original is not quite correct, for there are certain similes and illustrations, the originality of which everyone will readily concede, and will, at the same time, hope to find expunged in a future edition; we refer especially to the story of the Westerner on page 214.

In fact, the strength of Dr. Clevenger's work really lies in his forcible application of the laws discovered by Darwin and Spencer, to the consideration of many points in comparative physiology and anatomy. Thus he introduces (p. 40) his lucid explanation of the apparently anomalous distribution of the valves in the veins, by demonstrating that their position is simply a relic of ancestral progression on four limbs; and at the same time he shows that, owing to the gradual assumption of the erect posture, the femoral vessels, instead of being concealed safely from injury in a deep groin, as in the lower animals, are exposed to every assault.

But this is matter foreign to our limits of review, and therefore we must take leave of Dr. Clevenger's work with the suggestion that, for cosmopolitan readers, numerous Americanisms, if omitted, would render the meaning of many pithy sentences much clearer.

A System of Psychology. By DANIEL GREENLEAF THOMPSON.
2 vols. London: Longmans, Green, and Co., 1884.

In the modest preface the author says that, besides the little he may himself have contributed, "the reader is indebted for whatever science there is in this book chiefly to four other minds: to Julius H. Seelye, the personal teacher of my youth, who showed me that philosophy is possible and necessary for human welfare, and who inspired me with zeal for philosophising; to John Stuart Mill, the ever-influencing, though unseen friend of boyhood, youth, and manhood, who, with the first-named, taught me to love truth above all things else; to Herbert Spencer and Alexander Bain, who, with the second of the four, have shown me the paths of true knowledge in the department of psychology."

From this statement the general direction of Mr. Thompson's exposition may be gathered. The object is rather to systematize and to review our present psychological stores than to acquire new possessions; to scrutinize, to evaluate and to make accessible the territory we already possess, rather than to make additions either in the way of building up a new system, or in the way of breaking new ground. Such a work has a useful province; and there cannot be said to be a superfluity of books of the kind, at any rate in so far as the Association and Evolution Schools are concerned. Mr.

Thompson's work accomplishes its aim in a very successful manner.

From what has been said, it might be supposed that this system of psychology is merely a well executed epitome of the subject. Such a supposition, however, would be far from the truth. The author examines for himself the questions he deals with; and his treatment of them shows individuality of judgment. The style of the author's composition, too, though clear and forcible, is by no means the condensed style of a compendium. One more remark may be made as to the general character of the work. It deals with the principles of psychology much more fully than with descriptive psychology.

The plan adopted is stated as follows:—

Our special method in this work will be to begin with a general analysis of states of consciousness, with the object of ascertaining their elements, and observing what is implied or postulated in them, and what is distinctively characteristic of them. We shall then survey the physical or material conditions of states of consciousness, after which we shall be prepared to trace the genesis of states of consciousness. We will then proceed with a more detailed examination of the development of states of consciousness considered first on their cognitive, then on their emotional, and then on their volitional side. Having done thus much, there still remains a synthetical work of great importance, namely, to exhibit mental states as products of the operation of mental forces. Having studied the processes of mental action, we shall have to deal with the products in order to apprehend the relations of states of consciousness as wholes to each other, and to show mind, as a whole, in its influence upon other minds, and reflectively upon itself. This also furnishes a foundation for the other Ego sciences. Our task will be concluded with a consideration of the disintegration and dissolution of states of consciousness, and some remarks upon the connection of Mind and Body.

As the author's exposition is essentially that of the Evolutional branch of the Association School, it does not require to be summarised; and only a few points of interest will be noticed. The analysis of States of Consciousness is worked out in a twofold manner. In the first place States of Consciousness have three aspects—Feeling, Volition, and Cognition, which may be studied separately, but which do not exist apart. In the second place States of Consciousness are resolved into the elements of which they are composed. The constituents of consciousness, according to this analysis,

are the consciousness of difference, of agreement, of time, of representation, and of power. "No one of these can be analysed into anything else, and each one of them implies and postulates the others." One or more of the last three of these elements would be objected to by many psychologists; but the only one that calls for notice here is the "consciousness of power." This appears to be a somewhat inappropriate name; for it is apparently intended to signify merely the consciousness by the Ego of its own states.

Mr. Thompson's views concerning our cognitions of Space and Time differ considerably from other current doctrines. "Space, then, is not an empty void or vacuum, but is a material entity. Space is matter or body, and a space is a portion of matter or a body—a material thing." These somewhat metaphysical discussions, however, need hardly detain us.

A fairly good account is given of the bodily organism. But in this, as in many other parts of the treatise, the interdependence of parts, and the relation of fact with inference, is hardly sufficiently clear. That man has thirty-two permanent teeth, three pairs of salivary glands, one stomach, one large intestine, and one small intestine, may all be interesting facts; and no doubt a man's mental condition may depend very much on the condition of any of these organs. At the same time these, and pages of other matter throughout the book, will seem to most readers to be simply disjointed facts, loose stones in the path of the learner, or mere dirt clogging the exposition. In Mr. Spencer's all-embracing philosophy no fact comes amiss; each is a well-cemented brick in the edifice of knowledge. In Mr. Thompson's "System of Psychology" the bricks appear in many places to be laid together without cement, and consequently without coherence. This defect is no doubt due to the circumstance that an author does not always remember that a nexus between facts, though strikingly apparent to one who has long regarded it, may be imperceptible to those who have not previously considered it.

In treating of the Genesis of Feelings, the doctrine held by Bain, Hughlings-Jackson, and Wundt, that an efferent feeling attends the discharge of muscular energies is mentioned, Mr. Thompson supports the opposite view held by Bastian, Ferrier, and James. From Prof. James's paper on "The Feeling of Effort" (Boston, 1880) the following is quoted:—

I maintain that the feeling of muscular energy put forth is a complex of afferent sensation coming from the tense muscles, the strained ligaments, squeezed joints, fixed chest, closed glottis, contracted brow, clenched jaws, &c., &c. That there is over and above this another feeling of effort involved I do not deny ; but this latter is purely moral, and has nothing to do with the motor discharge. We shall study it at the end of this essay, and shall find it to be essentially identical with the effort to remember, with the effort to make a decision, or to attend to a disagreeable task.

The question of unconscious mental activities is full of interest. The author quotes from Dr. Carpenter, Mrs. Gaskell's account of Charlotte Brontë. "She said that it was not every day that she could write. Sometimes weeks or even months elapsed before she felt that she had anything to add to that portion of her story which was already written. Then, some morning she would waken up and the progress of her tale lay clear and bright before her in distinct division, its incidents and consequent thoughts being at such times more present to her mind than her actual life itself." Mr. Thompson relates his own experience to the same effect. He says, "again and again in the progress of this work I have turned my thoughts to the method of treatment of a topic without being able to satisfy myself as to how to arrange what knowledge I may have had upon the subject, and have had to wait for days, and once or twice for weeks, until I experienced a 'clearing-up,' after which I have been able to take my pen and write fluently and unhesitatingly the deliverances of my mind. I have best accomplished the *éclaircissement* by diverting myself in some way, sometimes by walking in the crowded streets of the city, sometimes by reading books leading the mind as far away as possible from psychology, and sometimes by attending a theatrical or musical performance. I have had at such times a sense of the uselessness of any voluntary effort to deal with the topic upon which I was hesitating, and also a feeling that the matter was working itself clear in my mind. Finally, on a sudden, usually in the morning after coffee, I would feel a readiness to write, a thought would occur to me which would give me the key to the situation, and directly I would find my trouble at an end, and the whole course of my exposition laid out before me with perfect distinctness. It has many times seemed to me that I was really a passive instrument in the hands of some power, not myself, which was working up thoughts for me independently of my own will. Perhaps

such experiences as these, with their proper scientific explanation, account for the apparently mysterious deliverances which the ignorant are prone to consider as revelations from supernatural sources. Let me add also that, in view of the necessity frequently arising of having to wait for the results of unconscious processes, I have formed the habit of anticipating—of getting together material in my mind for the treatment of a subject some distance ahead in my work, and leaving the mass to digest itself until I reach the point where I must commit to paper what I have to say on the subject.” Whether these are cases of unconscious mental activity may well be doubted. There is, at any rate, another explanation that looks as probable. The “process of digestion” may, so far from being an activity, be merely a forgetting of useless details and of irrelevant circumstances. In other words the process may be simply a fading away of the obstructive associations that in the first instance had hindered relevant thought. In mental perspective as in visual perspective, in order to view to the best advantage a complicated subject or a multiplicity of objects, a certain distance is required.

This explanation is of course not put forward to explain unconscious mental activity, but merely to show that in the present instance the so-called activity is really paralysis from disuse.

The relationships of Knowledge and Belief are discussed with considerable fulness. One of the conclusions arrived at is the following :—

Belief is allied with representative cognition, varying with the degree of representation ; where the representative element is in the ascendant, the state of consciousness is said to be more of belief than of knowledge ; and where the presentative element is prevailing, it is said to be more of knowledge than of belief. Believing may be described as the consciousness of an experience as representative. This is as near an approach to a definition as is here attempted.

A good deal of space is devoted to “Cognitive Integrations.” Under this heading the forms of Logic, the Canons of Induction, and the Rules of Syllogism are given, with an amount of detail more suitable to a work on Logic than to a work on Psychology. At the same time there is no mention of the controversy so long carried on between Mr. Mill and Mr. Spencer as to whether the Uniformity of Nature or the

Inconceivability of the Opposite is the ultimate criterion of truth.

The account given of Induction is rather misleading. As a type of inductive argument the following is given:—
“Robins, sparrows, eagles, &c., all the birds I have seen have feathers, all the birds I have not seen have feathers, all birds whatsoever have feathers.”

This is what Mr. Mill calls a “mere verbal transformation.” The conclusion is merely a different way of asserting what the premises have already stated. The inference is actually made in what here figures as the minor premise. In the further exposition of the subject, however, Mr. Mill is followed pretty closely.

In a chapter on Theories of Intuitional Knowledge the Intuitional Schools are acutely criticized, especially the Transcendental School, of which Dr. Hickok, in virtue of his “scientific expression (in attempt at least)” and his “extensive formulation of the rational philosophy,” is taken as the champion.

Touching the emotions, the author says: “The proper classifications of feelings are one showing the progressive development of pleasures and pains, and also one exhibiting the relations of feelings to ends of action as concerning the individual and the race.” “The classification of the emotions has always been a stumbling-block to psychologists, not from any want of acuteness or thoroughness on their part, but from the inherent difficulties of the subject. The complexities of these highly representative feelings, both as respects their composition and their relations to each other, and to other elements or aspects of mental life, are so great that we can scarcely analyze them, while to define them seems an impossibility. Except we follow out the orders of classification just referred to we can only make irregular groupings of feelings having a tolerable degree of homogeneity, but not being mutually exclusive in all cases.” With this latter course (of “irregular groupings”) the author contents himself in the earlier portion of his work. A systematic classification, however, is attempted later in the exposition. “Pleasures and pains may be divided into three classes—Primary, Secondary and Tertiary. Primary pleasures and pains are those of the fundamental appetitive sensations; secondary pleasures and pains are those attached to the immediate objects, concrete or abstract, through which

the individual considers that he has secured, and expects to secure, the primary pleasures and pains; tertiary pleasures and pains are those attached to the most general and abstract notions of what are regarded as causes of pleasures and pains." This scheme, unpromising as it looks, leads to a very interesting account of the emotions, an account, however, marked rather by illustration than by analysis or by description.

The extracts that have been given will afford some idea of the scope of the work and of the manner of its execution. The book may, without hesitation, be pronounced a good one; although the aspect of the subject is perhaps hardly that most likely to interest a medical reader.

W. R. H.

Insanity and its Treatment: Lectures on Treatment, Medical and Legal, of Insane Patients. By FIELDING BLANDFORD, M.D.Oxon. Third Edition. Edinburgh: Oliver and Boyd, 1884.

We welcome a new edition of this work, which is a very handy book for reference. Necessary changes and additions have been made to bring it up to date, but time does not materially affect much of what has been written in previous editions, inasmuch as the statements made and the opinions expressed to a very large extent closely follow Nature, and being based on observation are good for all time. Perhaps we ought to except from this remark the position taken in regard to cases in which the moral character is chiefly affected. Here we think the author hardly does justice to the subject, and that the student would receive an imperfect idea of the number of this most interesting and important class of cases, under whatever name they may be grouped. This is our only ground for criticism. The author may see his way in future editions to supply this deficiency. In the mean time, the reader would do well to supplement this portion of the work with Dr. Clouston's observations on Moral Insanity in his recent "Lectures."

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *American Retrospect.*

By D. HACK TUKE, F.R.C.P.

*The Insane in the United States.**I. *General Management and Treatment.*

In my recent visit to the asylums of the States of New Hampshire, Vermont, Massachusetts, New York, Pennsylvania, New Jersey, the District of Columbia, Illinois, Wisconsin, and Maryland, I found that, with some exceptions, their condition was satisfactory, many being admirably managed and reflecting great credit upon all engaged in their administration. As a class, the American Asylum Superintendents are excellent men, devoted to their work, and as honourable, intelligent, and humane as those in any other country. I can only, of course, speak of the asylums and physicians I know. Judging from report, I believe there are institutions in some localities which are in a very discreditable state.† In fact, it is quite recently that the treatment of patients in one of the asylums in a Western State was admittedly most disgraceful. And in several of the institutions I visited, the rooms occupied by patients were quite unsuitable, and the amount of mechanical restraint indefensible. I may go a step further, and say that in regard to the latter point there is in a considerable number of the asylums more resort to restraint than superintendents in England would approve, although I am by no means sure that in all these cases disapproval would be warranted. In many other American asylums there is either no restraint whatever or it is so slight and manifestly necessary for surgical reasons, that hypercriticism alone would find fault.

I have been favoured with certain unpublished returns of restraint made in 1880, but before giving them I must premise that it would be unfair to take these figures as giving a correct representation of the amount of restraint at the present time, because I am certain, from information received, and from my own observation, that the number

* Paper read at the Quarterly Meeting of the Medico-Psychological Association, held at Bethlem Hospital, Feb. 13, 1885.

† It was stated by an American physician, Dr. Dana, two years ago, that the condition of the insane in some of the Southern States "is particularly distressing;" and that in South Carolina hardly one-third can be cared for in the single State Hospital there. The asylum in Texas holds only one-fifth of the State insane. "The importunities of the few Medical Superintendents in the South show how negligent these States are." He asserts that the condition of the non-asylum insane in the Southern and Western States has little altered from what it was 10 years ago. "They are miserably kept in jails, almshouses, and on poor farms, &c."

restrained in asylums within the last few years has been greatly reduced. One is glad to know, also, that many who were then in almshouses, and were in restraint, have been removed to institutions for the insane in which little or no restraint is employed.

The number of patients in asylums in 1880 was 40,992, and the number reported to be under restraint 2,242, or 5.4 per cent. The mode of restraint was as follows:—

Camisole	...	...	...	...	887
Muff	...	...	...	...	526
Strap to bench...	...	...	...	...	439
Handcuff	...	...	...	...	147
Ball and chain	...	...	...	...	21
Crib-bed	...	...	...	...	111
Form of restraint not stated	...	...	...	...	111

2,242*

I should suppose the number returned under "crib-bed" is under the mark. Its incomplete return may be accounted for by the circumstance that it is scarcely regarded as mechanical restraint by some superintendents, inasmuch as it does not actually confine the limbs in one position. Outside asylums a return is given of the use of crib-beds, but I wish now to restrict myself to asylums proper, not almshouses or private care. The "ball and chain" reported as in use in 21 cases in asylums sounds strange to our ears. There were none in any asylums I visited; probably they are to be found in some Southern or far Western institution. Returning to the crib-bed which has caused so much acrimonious discussion, it would be disingenuous to deny that there are patients who are constantly getting out of bed, sometimes feeble elderly people; and others, restless, excited patients, who persist in standing up, and become very much exhausted, for whom it is an ingenious and sometimes effective device. I make this admission as I do not believe in that definition of travellers which defines them as persons who go abroad in order to lie for their country.† At the same time, the crib-bed is to me an unpleasant object, and inevitably suggests when occupied that you are looking at an animal in a cage. Moreover, it is so temptingly facile a mode of restraint, and is on that account so certain to be abused, that I hope it will not be introduced into this country among the useful American inventions we are so glad to possess. That whatever its occasional utility may be, it may be abused, will be admitted when I say I counted 50 in use in a single asylum, and that a very good institution in most respects. At the celebrated Utica Asylum, under Dr. Gray, where a suicidal woman was preserved from harm by this

* Also restraint by "personal attendance only," 1414.

† Or as the immoral Scotch proverb expresses it, "A travelled man hath leave to lie."

wooden enclosure, my companion, Dr. Baker,* of the York Retreat, allowed himself to be shut up in one of these beds.

On examining the journal of the Bloomingdale Asylum, New York, of which Dr. Nichols is the Superintendent (there being 247 patients), I found that from the 1st of January, 1884, to the date of my visit, in the third week of October last, two men had at times required restraint to prevent self-mutilation. I think none of you will be disposed to criticise the resort to restraint in these cases. On the women's side of the house there had been no mechanical restraint for two years, and no seclusion during the year. I may add that during the several days I was at the Bloomingdale Asylum there was one individual, and only one, to whom it was necessary to apply mechanical restraint, namely, the doctor's collie, which it was needful to muzzle for a snapping propensity which suddenly developed!

I would here say that in visiting the American asylums I carefully refrained from making non-restraint the measure by which I estimated them, but looked rather at the general comfort of the house and the patients as a whole, and had regard to the evident character and intention of those in authority. I had, of course, a great deal of conversation with superintendents on this inflammatory topic, and I should say that they feel that they have not always been fairly treated in the criticisms made upon them in this country.

What the American alienists complain of is this: they say that the British superintendents proclaim themselves the disciples of Hill and Conolly; that they protest in their writings against mechanical restraint as never necessary and always injurious; and yet when they (the Americans) visit our institutions they find some patients in restraint in the best conducted asylums, often for the same reasons for which they themselves resort to it, and for which they have been so severely criticised. Moreover, in conversation with some of the superintendents of British asylums they meet again and again, they say, with the frank admission, that the absolute disuse of mechanical restraint in accordance with the teachings of Hill and Conolly is not really held by them in theory, but is rather a "pious opinion."

Perhaps there has hardly been that public outspoken avowal of the occasional resort to restraint which the rare examples which do occur would seem to demand, whenever Conollyism is proclaimed as the adopted faith, and, by implication, the constant practice of the medical superintendents of British asylums. Thus the difference between American and English practice (if not principle) is made to appear still greater than it really is. The intelligent and humane physician in America who declines to bind himself by any formula or vow, and who, in the exercise of his unshackled judgment, applies the camisole in extreme and exceptional cases, is practically at one with the English alienist who calls himself a disciple of Conolly.

* Dr. Baker and myself visited ten of the United States asylums together. Including those in Canada I inspected forty.

Recurring to the allegation which led to these reflections, I will not deny that the American psychologists have some ground for their feeling on this question. It is not too much to say that an attempt has been made by some writers to divide cis-Atlantic and trans-Atlantic alienists into the sheep and the goats of the psychological kingdom. I shall rejoice if my reminiscences of American physicians engaged in the treatment of the insane have the effect of dispelling so exaggerated an opinion. As I have said, among the American alienists there is a large proportion of men as benevolent, intelligent, and devoted to their arduous work as their *confrères* in Britain, and while I sincerely hope that the practice of those of them who still resort to frequent restraint will before long accord with that of those of their own brethren who very rarely use it, I give them the fullest credit for pursuing their present practice with the honest conviction that it is the best for the patients under their charge,

Of *seclusion* I would say that while some superintendents, like Dr. Gray, state that they never resort to it, there was evidence of its use in many asylums to as great an extent as in Britain. In only one asylum, Danvers, Mass., did I see a padded room.

With regard to the care and inspection of *suicidal cases*, there is no uniformity in the American asylums. It is rare to concentrate such cases in one associated dormitory. More often the attention of the night-watch and of non-suicidal patients in the same room is relied upon, and in very active cases mechanical restraint would no doubt be resorted to during the night. At the Middletown Asylum, Connecticut, superintended by Dr. Shew, the suicidal patients are usually placed in a large dormitory, and those who are very actively suicidal have also an attendant sitting up with them. I may mention that since this asylum has been opened, 17 years ago, 4,000 patients have passed through it, and there have been 14 suicides, five of which occurred in one year. At Utica the suicidal are placed together.

Of 13,594 deaths occurring in American asylums in 146 years, 124, or nearly 1 per cent., were due to suicide. It is estimated that a suicide takes place in an asylum of average size every year and a half. Of admissions into asylums it is stated that from 15 to 25 per cent. have suicidal tendencies.

Nor is it usual to congregate all the *epileptic patients* together in the same dormitory. At the Government Hospital for the Insane at Washington, however, Dr. Godding has converted a large sewing-room into an associated dormitory for this purpose, and a large associated dormitory has been for some time in use at Kankakee.

With regard to the strictly *medical* treatment of the insane, I do not think there is much, if any, difference between the American and the English practice. Perhaps fewer new drugs are administered in the former than the latter. Hyoscyamine (Merck's) is used hypodermically (one-tenth to one-twelfth of a grain) in a good many asylums. Chloral and bromide of potassium are given to much the

same extent as they are in England—if anything, more in America—20 grains of each being a frequent dose at bed-time. In an asylum containing 780 patients, 15 draughts of chloral were prescribed on the evening of the day of my visit. At the Butler Hospital, Providence (R.I.), Dr. Sawyer was giving 10 grains of chloral, with 15 of bromide, at bed-time, repeated in the night if necessary. The usual remedies for intercurrent physical disorders are, of course, resorted to—quinine, iron, &c.—but nowhere did I hear of any special remedy put forward with confidence for the treatment of mental disorders. I am afraid that we have neither anything to teach nor learn from each other in the therapeutics of insanity. The American asylums are well supplied with baths, which are employed to much the same extent and under the same circumstances as with us, but I did not hear of the prolonged bath being used in any asylum. Shower-baths are, I believe, never made use of, and I am not aware that any asylum in the States besides Kankakee and Utica is provided with the Turkish bath. I did not meet with the wet or dry pack. Those who were present at our last annual meeting may remember that Dr. Nichols, the Superintendent of the Bloomingdale Asylum, New York, in his able and interesting speech, stated that he employed the warm bath with cold water to the head in suitable cases, followed by rubbing the whole surface of the body with whisky as a swelling is rubbed with liniment, and that this treatment often succeeded better in inducing sleep than the administration of any drug; at the same time allaying the fever and saving the strength of feeble patients. I observed the truth of his statement that shaving the head and applying counter-irritation do not form part of the practice of American asylums, this treatment being regarded as of doubtful advantage, and therefore scarcely justifiable. Preference is therefore given to blistering or cupping the nape of the neck, the temples or behind the ears. Dr. Nichols relies on opium in a few cases of mania and in some of melancholia. When I was at Bloomingdale (297 patients) I examined the Medical Record, and found at the time of my visit that no patients were taking hypnotics or sedatives, while 34 were taking tonics, 52 “miscellaneous medicines,” and 7 had medical baths. I do not think that the open-air treatment of maniacal patients is so frequent in the American asylums as in our own. It is not so common a practice there as here to employ one or two attendants to take such a patient out into the grounds or airing court and allow him to work off his excitement by exercise as well as improve his health by plenty of fresh air. Special attention has been paid to uterine affections in their relation to insanity in one at least of the American asylums. This has been facilitated, I should say, by the appointment of lady physicians in several of their institutions. With two of these, Dr. Margaret Cleaves and Dr. Garver, the former recently, and the latter now, the physician on the female side of the Harrisburg Asylum, and both intelligent and very anxious to advance the therapeutics of

uterine insanity, the result would seem to be that some cases have been benefited by the treatment pursued consequent on the knowledge of uterine disorders obtained by examinations which probably would not have been made in the ordinary routine of asylum treatment. At the same time I am afraid it must be confessed that these results are but scanty, and fall far short of what had been anticipated from the particular attention thus paid to this department of practice, and as I consider under very favourable auspices.

Useful, then, as this treatment has doubtless been, it is very far indeed from justifying the opinion of those obstetric physicians who think that if only the superintendents of asylums would examine and treat the uterine condition of many more patients than they are wont to do, the number relieved or cured would be much greater than it is at the present time.

In connection with treatment I would briefly refer to the *Recoveries* and *Deaths* in the American Asylums. I have not, however, a sufficient number of reliable statistics from which to draw any reliable inference. So far as I have obtained returns, I find that the rate of recoveries to admissions varies from 20 to 42 per cent. It is to be regretted that so many of the reports of these institutions give only the statistics of the past year, and not the results since the opening of the institution. As is well known Dr. Pliny Earle has carefully studied the curability of insanity and has done good service by pointing out the fallacy of counting the recoveries of a single case as if they represented so many recovered insane persons. He has shewn that in the American asylums the recoveries as reported were more frequent in the early than in the later periods of their history—a result which he attributes to the larger number of chronic cases transferred from almshouses to asylums; to the increase of general paralysis; to different modes of calculating recoveries; to the greater care exercised not to return patients as “recovered” who have only improved; to the small number of cases upon which early statistics were based; and lastly, to the greater tendency to retain patients under care to save them from relapse. As regards mortality it does not exceed 5 to 7 per cent. in the best asylums, calculated on the average number resident.

I must here say a word on the alleged difference of type in *the form or intensity of mental disorders* in the two countries.

It has seemed to several American alienists in visiting our asylums that English madmen present a milder type of excitement than those of their own country. Dr. Draper, the very intelligent superintendent of the Brattleboro Asylum, Vt., was strongly impressed with the difference between American and English patients on visiting this country some years since, and considered that violent excitement was comparatively transitory in our asylums, while it continues for months and even years in theirs. It is difficult, I think, to form an opinion on the subject by visiting asylums for a short period in either country. I attach great weight to the testimony which I obtained

from English attendants in American asylums, who themselves had been employed for years in this country. I questioned them closely, and they were, I found, distinctly of opinion that the patients they had had to manage in England were more violent and difficult to do with than those in America. The latter, according to my informants, are not (contrary to what might have been supposed) more impatient of control, or more tenacious in maintaining their individual rights.

Then as to the relative frequency of *general paralysis*. There has hitherto been, and there still is, decidedly less in the American asylums than in England, but I am sorry to say it is clearly on the increase, and bids fair to equal in amount that witnessed in the mother country. Till recently it was very rare indeed in women, but is becoming more frequent.

A few words may here be said in regard to the vitally important subject of *Employment*. I found at the Utica Asylum, containing 600 patients, that the average percentage of men employed is about 35 per cent., and of women nearly 38 per cent. I should add that from one-fourth to one-fifth of the inmates are pay patients.

At the Willard Asylum (N.Y.) out of 1,758 patients 801 are reported to be able and willing to engage in some kind of occupation.

Again, at the new asylum at Worcester, Massachusetts, where there are 780 patients, 38 per cent., namely, 102 men and 218 women, were occupied.

At the Northampton Asylum, the laundry work is done by an average of 530 persons, with only two employées (women), whose aggregate wage is £7 a month. For the last fifteen years, nearly or quite three-fourths (Dr. Earle thinks it may safely be placed at two-thirds) of all the *necessary manual labour* upon the premises has been performed by patients. And at this institution, as closely connected with employment, may be mentioned the remarkable extent to which in-door recreation in some form is carried out nearly every evening during the year.

It is creditable to the Norristown Asylum (Penn.) that of 510 male patients 167 were employed out of doors. Sixty-four were engaged in the brush-shop alone.

At the New York City Asylum for males (Ward's Island), under Dr. MacDonald, a printing press is in constant use, and there were four patients at work on the day of my visit, bookbinding being done as well as printing. Of the total number of patients (1,494) 34 per cent. were employed, 219 in outside and 298 in inside work. As many as 1,154 go out for exercise. Although I can hardly adduce bathing as an example of work, I may mention as a praiseworthy attempt to occupy the patients that salt water has been brought into the grounds so as to form a large bath 220 feet long by 30 feet broad, and from $4\frac{1}{2}$ to $5\frac{1}{2}$ in depth, where a number of patients bathe in the open air to their heart's content. From 500 to 600 patients bathe every day. There were as many as 200 in the water when I was there, and they evidently enjoyed their immersion immensely. There is a large

shed under which they dry themselves. This is the second year the bath has been in operation, and it has proved a great success.

As a useful mode in which to employ patients I may here mention that, at the Pennsylvania Hospital for the insane, till recently under Dr. Kirkbride's charge, a considerable number are engaged in pottery work, the clay being moulded by them into various useful and ornamental forms, specimens of which are collected in a room in the institution.

At the Middletown Asylum, Connecticut, superintended by Dr. Shew, 45 per cent. of the 892 patients were employed at this asylum, 26 being engaged on the farm, 37 on the grounds, and 18 in the stables.

When I come to speak of the system of providing for the chronic insane in the State of Wisconsin it will be shown that a very considerable amount of work is done by them in the small county asylums which are attached to almshouses.

It must be admitted that the above percentages are somewhat low, even for mixed asylums, as some of them are, and contrast strongly with the Sussex asylum, where 66 per cent. of the men are employed, exclusive of ward cleaners, 116 being engaged on the land; or with Brookwood, where, of 318 men, 163 are engaged on the farm and garden, and 66 at various trades.

There are two reasons assigned for this difference. The one is the greater independence of the people in America, the other the character of the climate. When I observed one day to an American doctor that on such a sunny day as that, our patients would be nearly all out of doors, "I should think they would in *England*," he replied, ironically, for he knew something of this sunless island of ours, and was not surprised to hear that when the sun does shine everyone turns out to see it. But, joking apart, I should hold that the English are in advance of the Americans in this very important matter of out-of-door occupations; and this is the more to be regretted when one considers the liberal supply of land which is attached to many of their asylums. There is already a movement in this direction, and I am inclined to think it will be found that neither independence of character nor peculiarities of climate will ultimately prevent the system being carried out to a greater extent than it is at present.

Dr. Dana refers, in an article in the "*Journal of Nervous and Mental Disease*,"* to the lack of sufficient work and amusement as an evil still existing in a large number of the asylums in his country, but adds that in some States the asylums are so miserably provided with money and even grounds that really little can be done. Among other State asylums, those of New York and Maryland appeal to the authorities for power to give their patients more work, exercise, and amusement.

It must, in this connection, be remembered, in justice to American asylums when compared with our own, that while in England men can work out of doors during the greater part of the year, there is little

* Vol. ix, No. 2, April, 1882.

or nothing to be done in many of the American States from November to April.

II. Lunacy Legislation.

I now pass on to the question of Lunacy Legislation, and as this excites so much interest in England at the present time, I will mention the practice pursued in several of the American States, the result of laws which have been enacted for the protection of the insane. As these laws vary with every State (nearly 50) it is impossible to do more than single out three or four as examples of the different plans which have been adopted, including those of the most drastic kind. It is as they bear upon admission into asylums, involving, as this does, the deprivation of liberty, and the inspection of asylums, that we are most concerned with these enactments, and the practice pursued.

A. *Admission*.—(a.) I will first take the simplest possible form of admission as it is found in the State of *Connecticut*. The request of admission for a private patient, signed by a guardian, near relative, or friend, simply requests that A. B., of C. D., may be admitted as a patient into the hospital for the insane.

The certificate of one physician is sufficient, and runs thus:—

“I hereby certify that I have, within one week of this date, made personal examination of A. B., of C. D., and believe him to be insane.”

This is subscribed and sworn to by the physician before an officer authorized to administer oaths, who certifies to the respectability of the physician and the genuineness of the signature.

(b.) If we now go to *Pennsylvania*, we find a considerable advance made in the stringency of the checks on improper admission into asylums, although I should observe that the law of *Pennsylvania* allows persons to place themselves voluntarily in an asylum for a period not exceeding seven days, on signing an agreement giving authority to detain them, which may be renewed from time to time for the same period.

In ordinary cases, in accordance with an Act of 1883, passed in consequence of a Commission appointed by the Governor of the State to report upon the Lunacy Laws, it is necessary that the medical certificate should be signed by at least two physicians actually in practice five years, who shall certify that they have separately examined the patient, and believe him to be insane and requiring the care of an asylum. They must not be related by blood or marriage to the patient, or connected medically or otherwise with the institution. This certificate must be made within one week of the examination of the patient, and within two weeks of his admission. Further it must be sworn to or affirmed before a judge or a magistrate, who must certify the genuineness of the signature, and the standing and good repute of the signers. It is not, however, necessary that the judge or magistrate should examine the patient, or express any opinion in regard to his insanity.

The order and statement are signed by the person at whose instance the patient is received. The statement comprises the chief points of importance, but is not so full as our own.

Copies of the admission papers are forwarded to the Committee on Lunacy, which is a section of the Board of Charities, within seven days of admission.

(c.) I will now give an example of a more stringent procedure, and for this purpose draw my illustration from the State of *Massachusetts*. Here, not only are the certificates of two physicians required (the facts upon which their opinions are founded being specified), but the Lunacy Act of this State requires that no person shall be committed to a lunatic hospital, asylum, or other receptacle for the insane, public or private, without an order signed by a judge of one of the various courts enumerated, certifying that *he finds that the person committed is insane, and fit for treatment in an asylum*. Some discretionary power is, however, permitted, for if the judge thinks it undesirable to see the patient, he may certify to that effect, and still commit him. Again, if he is in doubt, he may summon a jury of six to his aid.

To obviate the difficulties which might arise from requiring a judge's order and examination in urgent cases (difficulties to which we are so much alive in England), an emergency certificate is allowed, upon which the Superintendent may receive and detain a patient for five days. This document, signed by two physicians, certifies that the patient is labouring under violent and dangerous insanity, and it is accompanied by an application for admission from the Mayor or one of the Aldermen of the place in which the patient resides. Certainly the granting of this exceptional action in cases of emergency must materially lessen the inconvenience of the *Massachusetts* Act.

(d.) The last example, and the most stringent of all which I have to give, is in operation in the State of *Illinois*, where the law requires that no one shall be deprived of his liberty by being placed in an asylum without trial by jury. Instead of giving the details of the Act which requires this proceeding, I will briefly describe what I myself saw of trial of the insane by jury in Illinois when I was at Chicago last October. I went, accompanied by a solicitor (Mr. McCagg), on what is called "insane Thursday," to the County Court, where the trials are held, presided over by Judge Pendergast. Below the Court were some rooms occupied by insane persons awaiting their trial. In the Court itself, there were about 40 spectators. In one corner of the room sat the jury of six, the foreman being a doctor. When the patient was brought in for trial, a physician (Dr. Bluthardt) employed by the Court gave the result of his examination. A friend of the patient also gave evidence, and the judge asked a few questions. The jury then retired into an adjoining room to consider their verdict, and another case was tried. The consideration of the cases did not occupy much time, but there was no unseemly haste. One patient was too acutely maniacal to be examined in the Court, and was quickly con-

veyed through into another room, where the jury and the official doctor went and examined him. I followed. He was restrained by a leathern muff, and the jury made short work of the case. In one instance, after a careful inquiry into all the circumstances, the man was not found insane, although he was evidently not quite right, and it was agreed that he should go and reside with a farmer who was a friend of his. I had an opportunity of conversing with the judge, who told me that he regarded the law under which these trials are conducted as a satisfactory one. Insane Thursday is likely, I was told by others, to remain an institution in Illinois, as popular feeling demands trial by jury as a right. The publicity, however, is a serious objection, and I was informed that people often keep their friends at home rather than make their insanity known. The circumstance is almost sure to come out, although they often bribe the newspaper reporters not to report their friends' case, and though the judge, as he told me, sometimes considerably defers the trial of those cases in which he knows there is a dread of publicity until other cases have been disposed of, and the reporters have left the room.

In regard to jury-trial of the insane, Dr. Andrew McFarland, of Illinois, thus writes to another American physician, Dr. Parsons :—“The Illinois law of which you inquire is injurious, odious, barbarous, damnable, and you may add as many more expletives to it as you please, and still not say the truth in regard to its evils. . . . Every superintendent of an asylum in the State is most eloquently pleading for a change in this detestable system ; the Board of State Charities urges the change most forcibly ; a Bill is before the Legislature, reported favourably upon ; the Chairman of the Judiciary Committee is a true champion of the reform ; but all, as I fear, will amount to nothing, because there are a few fanatics who raise the hue and cry over an imaginary bugbear.”

Dr. Parsons himself objects to the jury-trial of the insane on the grounds that as the removal from home to an asylum necessitates publicity, to an odious extent, hospital treatment must be delayed in many cases until prospects of recovery have been seriously lessened ; that the transfer to a Court and the incidents of the trial often endanger the life of a patient ; and that in not a few instances, patients become dangerously excited by having to appear in Court as defendants.

Dr. Jewell, of Chicago, highly disapproves of the practice ; as also does Mr. F. H. Wines, the Secretary of the Illinois Board of Health. Mr. Wines writes : “A delicate woman, for example a case of puerperal insanity, is dragged from her bed in winter across the country to the county court, and carried into the Court-room, more dead than alive, before she can be taken to the hospital. . . . The effect of the trial on the patient is often terrible. He is impressed with the conviction that he has committed some crime, he knows not what ; he believes himself to be consigned to a prison ; possibly he has a sense of having

been dealt with unjustly and foully wronged; he looks upon the officers of the hospital as conspirators in a plot; it is long before a suspicion of them can be removed."

Dr. Dewey, of Kankakee, also objects to this law. He says that the unfortunate influence exerted by the patient having been treated as a criminal "is consequently apparent among the patients in our hospitals, an undue proportion of whom are impressed with the idea that they are unjustly accused of some crime and tyrannically held in confinement. . . . The best feelings of all right-minded persons are outraged by seeing presented in Court the depraved and unnatural acts and speech of otherwise reputable men and women."

From the description now given of these well-intentioned, if mistaken, enactments in force in the United States, it will be seen how much care has been taken in some of them to guard the liberty of the subject. There is certainly a good opportunity afforded of trying and observing various experiments in lunacy legislation, differing in their degrees of stringency, but having for their object the protection of those who are not able to protect themselves, and whom we all wish to see guarded from anything like unjustifiable interference, so long as this can be done without disadvantage to themselves, disaster to their friends, or danger to society. England would do well to profit by these experiments. She would hardly be induced, I should think, to copy the law of Illinois, and demand trial by jury for every alleged lunatic, private or public. I am not aware that in Massachusetts any considerable evil has attended the carrying out of the law requiring the examination of the patient, whether private or public, by a judge, guarded as this law is by an emergency certificate. Little, if any, objection applies to the simple guarantee on the part of the judge of the respectability of the signers of certificates, so long as this is accompanied by an emergency clause, by which the danger of delay in the admission of acute cases is obviated. It is worthy of consideration whether that part of the Pennsylvania law requiring the physicians who sign the certificates to have been five years in practice, is not worthy of adoption. Whether this, or the guarantee of the judge in regard to his respectability, would meet the demand now being made in this country for greater checks upon the admission of patients into asylums, is another question; for the public, or a certain section of it, might feel very suspicious in regard to mental physicians whom no judge or magistrate would for a moment hesitate to guarantee.

B. Inspection.—I now turn to the other point of Lunacy Legislation to which I have referred, namely, the vastly important subject of inspection.

(a.) At the present time the inspection of asylums is usually performed by State Boards of Charities, which have been constituted in a considerable number of the States, and are likely to increase. They had not been established in two of the States I visited, New Hampshire and Maryland. In Massachusetts there is an active and effective

Board. The first one was formed under a statute of 1863. About ten years later another Act authorised the appointment of two Commissioners in Lunacy, the first, I believe, ever appointed in the United States. In 1879, however, both these Boards were abolished, and the existing State Board of Health, Lunacy, and Charities, was appointed with enlarged powers. The members of the Board, with the exception of the secretary and clerks, receive no compensation whatever for their services, the expenses incurred in travelling being, of course, re-im-bursed. Whatever may be the reforms which it is desirable to introduce from America into England, I suppose this is hardly one which will find favour; at any rate, it is not likely to receive support from the Board in Whitehall Place. The Secretary visits the asylums frequently. I was fortunate in meeting with the present Secretary, Hon. F. B. Sanborn, a highly-intelligent man, interested in all questions connected with lunacy, and liked by the superintendents whose asylums he inspects.

The Board consists of nine persons, who are appointed by the Governor of the State with the advice and consent of the Council. It has the general supervision of the State Lunatic Hospitals and the State Almshouses as well as Schools. It must visit at least once a year all places where State paupers are supported, and must inspect every private asylum or receptacle for the insane at least once in every six months. It is expressly enacted that the Board shall act as "Commissioners of Lunacy," with power to investigate the question of the insanity and condition of any person committed to any public or private asylum, or restrained of his liberty by reason of alleged insanity in any place within the Commonwealth, power being given to the Commissioners to discharge any person not insane, or who can be cared for, if discharged, without danger to others or injury to himself (Act of 1882, chapter 87, section 1).

Dr. Pliny Earle (Northampton, Massachusetts) spoke favourably of the working of the Board. Dr. Draper, the Superintendent of the Brattleboro Asylum, Vt, did the same in regard to his State. Others felt evidently averse to a Board composed chiefly of laymen and laywomen, and were inclined to resent interference. That this feeling is natural must be admitted. Some irritation and annoyance will almost inevitably arise at times, in regard to advice tendered on points upon which doctors ought to be, if they are not, better judges than their advisers. But it appears to me that officious and harassing as individual members may sometimes be, such a Board is of use, and must certainly be continued until medical Lunacy Boards are introduced; and even then I should regard it as very desirable to secure the unpaid services of the same class of men and women as visitors, though no longer Commissioners. They would make any suggestions which might occur to them to the Trustees and to the Commissioners in Lunacy. Ladies may prove invaluable in this way, for they often see the necessity of certain comforts and changes which may escape

the attention of officials, and which, although seemingly very small, add greatly to the comfort of the patients.

(b.) In Pennsylvania a Committee of the State Board of Charities has been established as a Lunacy Board, whose business it is to attend to the lunacy department of the Board only. Formerly there was a mixed Committee, but it has been found best to separate the duties of asylum visitation from those of other charities. Only the Secretary, Dr. Ouart, is paid, and his time is occupied in the inspection of the asylums of the State, the condition of which he reports to the Committee, whose members visit according as the necessity arises. One able member, Dr. Morton, is the son-in-law of the late Dr. Kirkbride, and son of the author of "*Crania Americana*." With him I visited Norristown, the excellent asylum near Philadelphia, under Dr. Chase and Dr. Alice Bennett, which has contributed largely to the practical solution of the question of providing accommodation for the chronic insane in Pennsylvania.

(c.) In the State of New York there exists, in addition to the State Board of Charities, a Lunacy Commissioner, Dr. Stephen Smith, to whom, as well as to Dr. Gray, I am under obligations for help rendered in forwarding the objects I had in view. I have reason to believe that his visitations and reports have done good service. I regret that the salary of this office is not such as would allow of any physician renouncing private practice. It is no doubt considered that his whole time could not be occupied in inspecting the institutions in the State in which the insane are confined.

This is one of the difficulties connected with the appointment of Lunacy Boards, on our model, in each State—a proposal which has been much discussed by asylum-superintendents in America.

I found from Dr. Stearns, the Medical Superintendent of the Hartford Retreat, Connecticut (so long associated with the name of Dr. Butler), which I visited with great satisfaction, that he was disposed to regard the appointment of a Lunacy Board with favour, if it could be administered under the same conditions as in Britain. He fears it is impracticable in his own country, because there is no central appointing power or authority. Each State must make its own appointment; but the number of asylums, unless it be in the State of New York, is too few to make it worth while or possible to set apart one Board for such a purpose. Dr. Stearns is well acquainted with Britain, and fully concedes the benefit which has accrued from the appointment of our Lunacy Boards. A stranger may well hesitate to suggest a plan which a man so impartial and well able to judge as Dr. Stearns regards as not feasible in America. It seems a pity some States cannot join together, and so make it possible to have men with ample knowledge of the insane constituting a Board of Inspection without other duties to perform. But I am informed that such a scheme is not in accordance with precedent, and would never be adopted.

Again, Dr. Shew, the Medical Superintendent of the Connecticut State Asylum, at Middletown, has united with Dr. Stearns in obtaining information about Lunacy Boards, which has resulted in a report upon this subject. While the general sentiment expressed in this report is in accordance with what I have just stated, they heartily approve of a Supervising Board of some kind in each State of the Union, and they propose that such Board shall consist of at least five members, eminent in psychological or humanitarian work. They wisely do not contend for a name, whether "Commissioners in Lunacy," "Inspectors of Charities," or a "Board of State Charities," provided that the Lunacy Board in England or Scotland be taken as, on the whole, the best model to copy.

III. *Provision for Chronic Insane. Segregation.*

The subject of the best form of provision that can be made for the chronic insane has greatly occupied and agitated the minds of physicians, philanthropists, and the Legislature in the United States during recent years. It will tend to a clearer view of the claims made upon the States of America in connection with their insane population if I state that at the last census, 1880, the number reported to be insane amounted to 91,959, or 1 in 545 of the general population, and the number of idiots to 76,895, making a total of 168,854. The distribution of the insane was as follows:—

In hospitals for the insane and asylums*	...	40,942 or 44·42 p.c.
Other benevolent institutions	... ..	235 or ·26 p.c.
In almshouses	... ..	9,302 or 10·12 p.c.
In jails, &c....	... ..	397 or ·43 p.c.
At home or in private families	... ..	41,083 or 44·68 p.c.
Total	... ..	<hr/>91,959 <hr/>

Thus, no fewer than 50,782, or 55·23 per cent., were not in any institutions. The asylums have been much crowded, and many efforts have been made, and some carried out, to supplement existing asylums by buildings of a less expensive character. Of this we witness one example in an Eastern and another in a Western State, namely, the Asylums of Willard† and Kankakee, which are examples on a large scale of what has been and is being done by other institutions in the same direction. This problem, which has occasioned so much discussion and led to such definite action in England, was discussed at a meeting of the New England Psychological Society in Boston last September, when I listened with much interest to the various opinions expressed by its members elicited by a paper read by Dr. Quimby, the Superintendent of the Asylum for the Chronic Insane at Worcester, Mass. Considerable diversity of sentiment prevailed. Some

* It is said that 90 per cent. of the insane in this category are incurable.

† So called from Dr. Willard. It is at Ovid, N.Y.

preferred retaining the acute and chronic in the same building, the necessary additions being made as accumulation rendered the original capacity insufficient; others advocated distinct asylums, whether in the same or different localities. All admitted the existing pressure and the necessity for further accommodation. The venerable President, Dr. Pliny Earle, observed that he did not see what disadvantage would result were he, for example, to reside in one building and an assistant medical officer in another, one taking charge of the acute, the other of the chronic cases. On the whole the balance of opinion in this debate was in favour of annexes or cottages on the same estate as the original hospitals.

I must here dilate a little on the Willard institution. Its establishment was the outcome of an attempt made in the State of New York to grapple with this problem of chronic insanity and to rescue lunatics from the neglect and cruelty from which many of them suffered in almshouses. In common with some similar attempts, it was a considerable departure from beaten tracks and the tradition of the elders. Dr. Chapin led the way, and superintended the group of buildings known as the Willard Asylum, from its opening in 1869 to 1884. He informed me that the idea was first suggested to him by the Fitz-James Asylum in France. I met Dr. Chapin in Philadelphia, where he has succeeded the lamented Dr. Kirkbride in the management of the Pennsylvania Hospital for the Insane, and conversed with him very fully in regard to the disposition and arrangement of the detached buildings at the Willard Asylum, and heard from him in what respects the experiment has proved a success. Although I regretted being unable to visit the institution itself, I was made so thoroughly acquainted with it by the descriptions of my informant that, like a certain royal personage who seriously maintained before Wellington that he was present at the Battle of Waterloo, I have for some time entertained the idea of having actually visited the Willard Asylum. Be this as it may, it is always better to behold the *genius loci* than merely the place from which it has departed; that is to say, when one cannot see both.

When "Willard" was opened there were as many as 1,500 lunatics in almshouses in the State of New York, while there were only 500 in the State Asylum at Utica, under the charge of Dr. Gray. Four years before Willard was opened, there were as many as 200 pauper lunatics in chains in the almshouses of the State.

Dr. Chapin claims as important advantages in the Willard Asylum system: first, economy of construction; secondly, economy of maintenance; and, thirdly, greater facility for taking patients out to work on the farm.

Without entering into details, I may state that it provides for about 1,800 patients, and is the largest asylum in the States. The main building contains nearly 600 patients; Dr. Chapin, however, disapproves of so large a number, preferring 300. There are also

four groups of detached blocks, each group comprising five, making 20. There is another building, formerly an agricultural college, adapted to the requirements of the insane. The cost of three buildings, which are to be erected for 200 patients in all, will be under £50 per bed, exclusive of land and furniture. One of the detached buildings accommodates 250 women, a matron and assisting physician residing there. All patients, when admitted, go in the first instance to the central building, and are subsequently classified and distributed according to their mental condition. Profiting by his experience at Willard, Dr. Chapin would prefer having only 50 patients in a detached building. At present there is a kitchen provided in every house, but if he only had houses with a capacity for 50 patients, Dr. Chapin would plan to have a kitchen and large dining-room for common use in a separate building.

I will now ask you to accompany me to the other locality, Kankakee, Illinois, some 50 miles from Chicago, where a similar, though in some respects, a different experiment has been made. Some years ago, a gentleman was deputed by this State to visit the asylums of Britain before a decision was arrived at as to the best mode of construction to adopt in the erection of a new State Asylum. Those who, like myself, met Mr. Wines in England, will remember the careful and intelligent study which he made of our institutions. On his return he recommended the erection of a main building and several others entirely detached from it, with the view of avoiding one huge high-storeyed building, and facilitating classification, by providing dwellings as much as possible resembling those to which the patients had been accustomed at home. Segregation is here carried out to its fullest extent, and, as some think, to an objectionable extreme. Apart from any errors of detail which may have been committed, it is a pleasant thing to see this breaking up of buildings on so extensive a scale. It must do good. The air blows more freely and freshly through this group of houses, which will soon form a little village, than it would or can through monster structures filled from top to bottom with the insane. I saw with pleasure, one evening, a number of patients sitting at ease under the verandah of one of these cottages, some of them, if not all, having been engaged in wholesome work on the farm during the day. There was an air of freedom and homeishness which is necessarily more or less lost in an ordinary asylum, especially when of giant proportions. And I may say that, although not a few in the States look with a critical eye at what they regard as segregation run mad, the principle itself, that of providing the requisite number of small buildings in place of one, is rapidly advancing in the United States. In fact, there has always been a strong feeling against the aggregation of a large number of patients under one roof; but until comparatively recent times it did not become necessary, (or perhaps it would be more correct to say the necessity was not recognised), to provide

asylum accommodation for a large number of acute and chronic cases in every State of the Union.

The asylum of Kankakee was built in 1878 and '81. When I visited it I found some of the detached buildings in course of erection, and more will eventually be built. There are 1480 acres. Dr. Dewey is the superintendent, and speaks warmly of the success of the experiment. The number of patients at the present time is 615 (370 men, 245 women). Eventually there will be accommodation for 1500 patients. One large unfurnished building contains a dining hall for 500 patients, 85ft. by 67ft., and is very light and well proportioned. Below this room is the kitchen. The patients will come here to dine from the detached buildings for males.

At the present time dinners are conveyed by hand cars from the main building to the cottages, and, as the distance is considerable, there has been a good deal of criticism on this part of the arrangement, but I was assured that the food was not more chilled in the transit from the central kitchen to the detached buildings than it is to the extreme ends of the main building itself. It is intended, however, to make use of a special apparatus invented by the New York Catering Company, for keeping meat warm when carried from one spot to another.

I may add that one of the buildings is an infirmary; the rooms are well adapted for the wards of a general hospital. I regret to say that this building, which was only just occupied at the time of my visit, has been recently burnt, the lives of a number of the patients being lost. One of the houses is called the "Convalescent Home;" another is the "Relief Building," which provides for 50 epileptic patients and 21 criminal lunatics. They appeared to be under very good care (one attendant was from an English asylum), and no patients were under mechanical restraint. There is also a recreation hall, used as a chapel as well, which accommodates 350. As is usual in American asylums, ministers of various denominations from the neighbouring town conduct the services in rotation. While I was at Kankakee there was an entertainment in the evening in this hall, at which there was music and dancing. In harmony with the ruling idea of making as little difference as possible between home and asylum life, the recreation hall is not connected by any covered passage with the main building, for it is thought that while, on very cold evenings, some patients may be deprived of the pleasure of the entertainment, something is gained from the freshness and change consequent upon having to dress and go to a distinct building.

I should mention that at Washington, also, Dr. Nichols, and his successor Dr. Godding, have favoured the erection of small additional buildings at Saint Elizabeth, the Government Hospital for the Insane. There was, in the first instance, a cottage for the patients of colour, and subsequently have been erected detached buildings for (1) feeble-minded children; (2) quiet, working patients,

"The Home ;" and (3) the "Relief House," for tranquil patients ; and lastly, "The Rest," the name given to the pathological room and mortuary. Here the body is placed in a refrigerator, which is situated between these two rooms, and can be conveyed to either when required.

Dr. Shew has carried out the plan of separate buildings at the Middletown Asylum, Connecticut, where there are 900 patients. Here is one annexe for 325 men and women patients, the cooking being done in the building. An assistant medical officer and his wife reside here.

An unfinished building, which will be three storeys in height, is designed for chronic cases and epileptics.

In addition to these annexes are no less than 5 cottages for 25, 20, 33, 16, and 26 patients respectively.

At Norristown, near Philadelphia, segregation has also been carried out to a considerable extent.

Again, at the Concord Asylum, New Hampshire, a very attractive cottage has been erected at the suggestion of Dr. Bancroft, for a select number of female patients, whose mental condition allows of their living in an ordinary residence. The provision here is on a small scale, and does not profess to provide for the chronic insane.

At Brattleboro, also, in the State of Vermont, Dr. Draper has what is called the "Summer Retreat," built like a Swiss chalet, and accommodating 20 patients. With its land of 20 acres and the furniture, this house cost £300 per bed. At this Asylum there is also a separate building for criminal lunatics.

I will next describe the course pursued in another State, Wisconsin, with a view of providing accommodation for chronic lunatics at a moderate cost. There are already three State asylums receiving both acute and chronic cases, but they are much crowded, and there is constant pressure upon the authorities for more room. When we consider the vast sums which have been spent upon the construction of the proverbial palatial asylums, amounting, in some instances, to £600 per bed, and this without any extraordinary curative results, we cannot be surprised that guardians of the poor and boards of charities should make a desperate effort to escape such expenditure, and should set themselves to work to provide humbler domiciles for at least the more harmless and chronic class of patients—those who are, for the most part, regarded beyond the reach of cure. Thanks to the Wisconsin State Board of Charities, I had every facility afforded me for examining these Institutions, and from this body collectively, as well as from its Chairman, Mr. Elmore, and its Secretary, Professor Wright, individually, I received the most kind and considerate attention during the time I was inquiring into the operation of the system which they have adopted. This may be described in brief as County care under State supervision. In accordance with a law passed several years ago:—

Whenever the total number of insane persons in this State shall exceed the total number of such persons who can be conveniently and properly cared for

in the State Institutions for the Insane already existing under the laws of this State, the Board of Supervisors of any county in this State, upon the conditions hereinafter named, may purchase or otherwise provide a proper site, within said county, for the erection of a county asylum for the care of the insane and inebriate persons, said site to contain not less than 40 acres; and when said site shall have been approved by the Governor, such Board of Supervisors may proceed, as hereinafter provided, to erect thereon suitable buildings for the proper care of the number of insane and inebriate persons, not less than 30 nor more than 50 per centum greater than the entire number of insane persons then belonging to such county, as such Board of Supervisors may determine.

But the County Board of Supervisors does not possess the power to decide whether the counties care properly or not for their insane, upon which depends the all-important matter of an appropriation from State. This power rests with the State Board of Charities, and was conferred by the law of 1881, chap. 233, and runs thus:—

“Whenever it shall appear to the State Board of Charities and Reform that insufficient provision has been made for the care and support of the insane in the State Hospitals and County Asylums previously established, &c., the said Board may file with the Secretary of State a list of counties in which no County Asylum exists, and which counties, in the opinion of the Board, possesses accommodation for the proper care of the chronic insane; and thereafter each of the said counties so-named, which shall care for its chronic insane under such rules as the said Board shall prescribe, &c., shall receive 1 dollar 50 cents (6s. 3d.) per week for each person so cared for.”

It is obviously important that the State should exercise this supervision over counties in regard to their asylums, but in no other State having them, is this check provided except in New York, and there the Board, although it inspects, does not possess the State appropriation at command to support its action.

Thus, the counties which take care of their insane under the authority of the Board, receive 6s. 3d. a week for each person so cared for.* I may state that, during last year, £9,845 was paid by the State of Wisconsin for this object. Existing almshouses are adapted to their purpose by the Board, or small asylums are built in their neighbourhood. In the Consolidated Monthly Report of Chronic Insane under County Care in this State, under the provisions of the above-mentioned Act, it is stated that there are 11 counties with asylums varying in capacity from 39 to 89 beds, and containing in all 618 patients. It may be added that 386, or 62·4 per cent., of these patients were employed, and that 3 have been discharged recovered during the month out of this chronic class. One patient had been in continuous, and 3 in temporary restraint.

I found these small county asylums on the whole in a satisfactory condition. The superintendents or masters of the house are laymen of a respectable farmer class, and a medical man in the neighbour-

* Last year it cost the counties 11d. more a week per head than they received from the State, without allowing for the investment in buildings and land. It is stated that the salaries of attendants are much the same in County and in State asylums. The total cost of chronic insane per head per week in the latter is exactly 3·89½ dollars, while in the County asylums it is only 1·72.

hood is engaged to visit periodically and oftener if necessary. There is a considerable amount of land attached to these houses, and on visiting one of them (Dane,) where there were 97 patients, I found 16 with an attendant engaged in husking corn. Ordinarily a larger number work on the land. One of them had, previously to admission, been confined in a small pen in an almshouse, while others had been rescued from neglect or cruel treatment. The patients chop up a great deal of wood in the winter, and slight rewards are given to workers by way of encouragement. As I approached this house I observed that the door and several of the windows were wide open, and that no bars of any kind were to be seen. In the dietary of that day the patients had coffee for breakfast, with eggs, pork, and potatoes; while for dinner they had beef, potatoes, and parsnips. For supper they had tea or milk, with mush (corn meal), bread and syrup, and some had pie. This Institution cost about £6,800, or £68 a bed. In regard to restraint, I found, on referring to the record, that three patients had been restrained in the course of the year. Seclusion had been rarely resorted to. The master, Mr. Myers, evidently felt a warm interest in the patients, and took great pains to induce them to employ themselves. He has a salary of £200 a year. The visiting medical officer has £40.

In another of these asylums (Juneau), built at a cost of £60 a bed, and having a capacity for 90 patients, I found a considerable number employed in the potato field, in digging, and in husking corn. Some of the latter were formerly immured in the cells of a wretched "crazy-house," for long used in connection with the almshouse. Maize, potatoes, barley, oats, hay, tomatoes, peas, beet, beans, turnips, parsnips, cabbage and celery, are raised on the farm. Some patients take the entire charge of the cowhouse, and two are employed to milk the cows. Twenty women were employed in the Institution, and four in the adjoining poor-house. The mistress of the house, who was formerly at the old poor-house, gave a graphic description of the condition of the patients at that time in the crazy-houses hard by, which I visited. They are interesting in their present empty state, as relics of the past. The patients used to lie on the straw either naked or in "slips," generally without any underclothing. The food used to be given to them on a tin plate thrust through a hole in the door. No knives or forks were used, and a patient would often throw the food on the straw and eat it like an animal. The straw was removed from these pens with a pitchfork. When the present treatment was introduced, the patients had to be taught cleanly habits like children, and made to dress, come to table, and go to bed. I saw an epileptic woman, a German, who had been confined in one of these pens. When they dressed her in blue calico she was mightily pleased, and exclaimed, "Schön!" There are 10 men and 10 women in this asylum who formerly were in the crazy-houses. One day the mistress took an old woman who had been immured there to revisit them. "She was that

uneasy and wild, and said, 'Are you going to put me into that crazy-house again? Why don't you burn it up?'" The cost per week, including clothing, is 8s. 9d. for each patient. I was curious to examine the record of restraint and seclusion in this somewhat out-of-the-way Institution, and I thought it worthy of transcription:—

June 15th, 1884.—A. B., shut up in room 8 hours for quarrelling. Result good.

July 5th.—Ditto, 9 hours for quarrelling. Result, good.

July 29th.—Ditto, 16 hours for disobeying and using indecent language. Result, promised to behave in future.

Nov. 8th.—J. L., shut up in room 9 hours, for raising a chair on an attendant. Result, promised good behaviour in future.

Dec. 3rd.—C. D., shut up in his room for 10 hours, for assault on attendant. Result, don't seem to have much, if any, effect.

Sept. 8th.—C. D., shut up in his room half a day, for striking an inmate. Result, don't seem to mind restraint much.

No women had been in restraint or seclusion.

At another similar Institution (Johnstown), where there were 75 patients, the master and his wife appeared to be thoroughly interested in their work. Active and successful efforts were made to employ the patients. The first three patients I saw were busy in the yard with a cart and potatoes just brought from the field. One patient who had been admitted from a State asylum, in regard to whom the master was warned that he must only allow him the use of a tin plate at meals, was put to work the day after admission, and the result has been very satisfactory. One patient was out with the team six miles off. I saw sixteen patients working in a potato field without an attendant, a competent patient acting as overseer. They work five hours a day, and I was glad to hear the master observe that it was not wise to let them work until they are sick of it. On examining the record of restraint for the year ending October, 1884, I did not find more than one case of restraint, viz., by mittens half a day in June, for violence and striking an attendant. Seclusion had been employed five times for four different cases. Wristlets, mittens, and the camisole had been used during the previous year, but to a very slight extent. Two crib beds were in use, one for an idiot, and another for a restless, elderly man, constantly getting out of bed. I should be glad to think that they are never used less considerably in any of the State asylums on the American Continent. A physician, Dr. Rockwell, resides half a mile off, and visits the house nearly every day. The estimated annual value of the labour done by the 75 inmates is upwards of £200. It was estimated that the labour of 16 of the patients was equal to that of the same number of sane persons; that of 20 equal to half (or rather more) of ordinary work people, 15 below this mark, and there were 24 who could not work at all.

Many fear that the system thus pursued in Wisconsin in providing for chronic cases will end in grief as it has done before, and that these institutions in the course of time will become as great a scandal as the old almshouses. However excellent the present Board of Charities

may be (and in my judgment is), it is urged that its constitution will change ere long, and that inferior men will very probably be appointed. In reply to these objections it is said that the management of the State asylums themselves may fluctuate according to the composition of their Boards, and that in regard to mechanical restraint it is at least as great in these institutions, as in the county houses. Further, it is alleged that the County Boards of Supervisors, which are assumed to be composed of an inferior class of men, are by no means insusceptible to influence in the right direction from the State Board of Charities, who meet with them and explain the objects in view and the means by which it considers it necessary to obtain them. Political motives, it is admitted, are a source of weakness and danger.

It is very clear that the success of the system requires constant care in the selection of cases, and the appointment of similar able and well intentioned men on the Board of Charities, as well as thoroughly reliable masters. Otherwise there will inevitably be a return of the evils from which the insane have escaped in the old almshouses. It is a noteworthy fact that at the present moment in England, the Lunacy Commissioners are encouraging the increased use of work-houses for the chronic insane by the recent action they have taken in regard to county asylums sending a number of this class to work-houses.

Nothing has been done in America in imitation of Gheel, and there does not appear to be any tendency in that direction.

IV. *Relative Merits of English and American Asylums.*

I wish that I could now convey in a few words by way of summary a just idea of the respective merits and demerits of American and English asylums, but this is not altogether an easy, and is certainly rather an invidious task.

Instead of directly giving the palm to either (though what may be regarded as insular prejudice would scarcely allow of my being discontented with our own), I would say that I believe each has something to learn from the other.

I think, first, that English asylum-superintendents will, in passing through the wards of American asylums, pick up not a few hints in regard to practical details which they would find very useful indeed. The Americans are so ingenious and inventive a people that it would have been strange had their asylums not borne some evidence of it, and there are many little, but important matters in which this inventive faculty is applied to the good working of the institution.

Again, I think the Americans have been wiser than ourselves in avoiding the construction of so many very large asylums.

A third advantage on their side, and partly due to this circumstance, is the greater proportion of medical men in most asylums in the States than obtains in England, and consequently the possibility, to say the least, of more individual interest in the patients and their treatment. The proportion varies considerably in different States, but

on taking the average of a number of American asylums I found it to be 1 in 150 ; while on making a similar calculation for those in England I found it 1 in 300. At the New York City Asylum for about 1,500 male patients, there were 15 assistants, several of these being clinical clerks.

Further, I like the more frequent practice of having married assistant medical officers. It is thought to introduce or retain a better class of men, and to give greater confidence to the friends of patients, especially in the absence of the superintendent.

They are better paid than with us. Some receive £300 and £380 a year. Attendants are also very liberally paid ; male supervisors receiving from £70 to £100 a year, and ordinary attendants reaching from £50 to £60 ; female attendants receive £30 to £50 ; matrons and stewards are handsomely paid. The Superintendents themselves are, strange to say, rather under-paid, and have no pension.

I may mention here, in passing, that a good plan is adopted among the American superintendents of New England of keeping a "black list" of attendants. Thus Dr. Pliny Earle recently warned the Superintendent of the Middletown Asylum (Dr. Shew) in the words, "Beware of Brown." Another superintendent wrote opposite the name of Smith, a discharged attendant, "very bad fellow," and another wrote, "discharged Jones for rough usage of an excited patient ;" while in a fourth the attendant was labelled "intemperate."

I am not sure whether or not I should set down to the credit of the State asylums in America that there are usually some paying patients mixed with the others who are supported by the State or County. It is strongly urged that this helps to raise the tone of the institution, and that the non-paying class are the gainers by this admixture of classes. It may be so. I have my doubts, however ; and rather incline to the restriction of State asylums in America or County asylums in England to the pauper class.

The idea that the State should provide accommodation for the insane of all social classes has long prevailed in America. Dr. Kirkbride maintained very strongly that "there is no justification for a State providing accommodation for one portion of its insane, and leaving the rest uncared for." English opinion, on the other hand, has travelled in just the opposite direction, and the State has not seen its way to provide asylums for private patients. Whether we are coming to this, and are about to Americanize our institutions, remains to be seen. There may have been a tendency in the United States to allow a disproportionate number of paying patients to occupy the State asylums. Until recently many patients of the pauper class were crowded out of these institutions, and suffered from the gross neglect which befell them in almshouses. Now that this evil is to a considerable extent rectified, the friends of the higher class patients require more provision for their relatives, and the consequence is that private asylums are on the increase.

It has been said that the classification of the insane in asylums is more perfect in America than in England, but I cannot say that I was struck with this difference myself, although the arrangements for dividing the corridors at will by folding doors are especially good in some asylums. Dr. Kirkbride had eight separate wards in his asylum, but I do not think that these divisions resulted in much, if any, more practical differentiation of cases than obtains in our asylums; and, indeed, the rule which he laid down for the basis of classification—the bringing into the same ward patients who would consort well together, and the separation of those who would not—had too much common-sense and simplicity in it to allow of much complexity of arrangement.

I think I ought to mention the development of the system of the segregation of patients, to which I have referred, as at the present time a feature in American practice, for although detached buildings for different classes have been long advocated and practised in British asylums,* and were at one period discountenanced by the alienists in the United States, the separation of cases differing in their mental character, and therefore requirements, has now been carried to such an extent, and as some hold to such an extreme, that it really forms a marked feature of recent and present movements among the promoters and organizers of asylum provision in the States. I think, therefore, that this strong tendency to segregation which has manifested itself, must be regarded as possessing greater momentum in America at the present moment than even in this country, and that we shall be able to learn something, or be confirmed in what we have already learned, by the plans now being carried out in some of the States.

I am, on the whole, disposed to reckon among the advantageous courses pursued by the Americans, the appointment of lady-physicians in some of their asylums—a practice which is certainly growing. I regard it as an experiment, and I think we ought to be grateful to our friends across the water for making it. I would go further, and say that if the lady-doctors of the future should be equal in ability and high moral character to those who have hitherto held office, and, if their position is so clearly marked out as to prevent all clashing with other members of the medical staff, they will prove a decided blessing to the female patients in asylums and a real help to the medical superintendents.

Before leaving the congenial task of pointing out the merits of the institutions of our Transatlantic brethren, I must not omit to mention the favourable impression I received as to the diet allowed the patients. I consider it more liberal and as having more variety than in our own asylums.

As to the comparative demerits of the American asylums, I would

* It was originally intended to build the new Worcester Asylum (Mass.) in detached buildings, to the same extent as at Whittingham (Lancashire), but the intention was abandoned.

repeat that in some, especially the old American institutions, there is not so much employment of the patients as there might be, and as, for the most part, is carried out in those of our own country.

On another point I think that British asylums show to better advantage than those on the other side the Atlantic. I was struck with the generally bare, unfurnished condition of the galleries occupied by the excited patients in the latter. I never saw, for instance, such comfortable looking quarters for this class as those provided in the asylum in which we meet to-day, or, to take a pauper asylum, in that at Prestwich; in both instances old asylums made to look homeish and comfortable by the pains taken to furnish them in the way English people like to have their own houses furnished and decorated. There are, no doubt, some rooms in some American Asylums which would not only equal, but surpass, those in our asylums, whether Registered Hospitals or for the County, and this must account for two of my American friends having been struck in exactly the opposite way to what I have been, for they specified the bareness of English Asylums as one chief point in which they are inferior to their own.

Then, of course, in regard to mechanical restraints, you will infer from what I have already said, that I regard the lesser amount of restraint in British Asylums as preferable to the greater amount of restraint in those in the United States. Still, notwithstanding this criticism, there is a growing tendency on the part of superintendents of American asylums to trust the patients with more liberty, and to remove unnecessary signs of forcible detention and unsightly means taken to protect glass, &c., from injury. Thus, in some instances, they have removed from the corridors, iron frameworks which were formerly used to protect the windows, a few feet from (and within) which they were placed. The panes themselves have been made larger and the bars less frequent, while small glazed apertures high up in single rooms have been lowered and enlarged. I am now speaking of the main buildings. In the annexes and cottages, anything partaking of the character of a prison is for the most part altogether absent. All this indicates a healthy feeling and breadth. It shows, along with the breaking up of one monotonous building into several, that whatever faults there may have been in past times in regard to the sameness of asylum wards, there is at the present time a vigorous effort to adapt the construction of the buildings tenanted by the insane to the very various mental conditions which they present.

In conclusion I would say that the outlook with regard to the future of the insane in the United States is very encouraging.

To say that the asylum physicians of America have not utilized to the extent they ought to have done the materials at their command; that their annual reports are defective in scientific results; that they have made no great reliable discoveries in the treatment of insanity, is, alas, only to bring a charge against them which is frequently brought against the superintendents of asylums in our own country.

In both countries those who are thus charged will sorrowfully admit that there is only too much truth in the criticism; but they will, while pleading guilty to their shortcomings, ask for an indulgent judgment on the ground of the mass of routine work which falls to their lot. With regard to American asylums, there is a special pathologist, Dr. Deecke, at Dr. Gray's Asylum, Utica, whose micro-photographic sections of the whole area of the brain and cord are well known. There is a pathologist at the Washington Asylum also. At the Middletown Asylum, Connecticut, under Dr. Shew's care, much attention is paid to microscopic work; while I may mention that at the Norristown Asylum, near Philadelphia, a lady physician performs the pathological duties of the institution. Outside asylums, cerebral morbid anatomy has been pursued by neurologists and alienists, but I must restrict myself on this occasion to hospitals for the insane.

The American authorities have had enormous difficulties to contend with from the fact of society in America being in a state of continual fusion, including the mixture of races consequent upon immigration. When we are disposed to condemn the long-continued lamentable neglect of lunatics in almshouses, and the slow progress made in improving the condition of even some of the large asylums, especially the institutions in the Western States, and their absence or insufficiency in the Southern States, we ought to remember that a very large mass of insanity has been thrown upon the American Townships, Counties and States, very much against their will. We can well understand how this must have been the case when we know that between 1820 and 1850, 2,250,000 emigrants landed in the United States, leaving one-tenth of the population foreign. The number of insane in 1850 was 15,610 and of these, 2,049, or no less than one-seventh, were foreigners. During the succeeding ten years, immigration increased so much that there were, in 1860, 4,136,000 foreigners, or about one-eighth of the population, while the insane foreign element amounted to 5,768, or one-quarter of the number of insane in the States (24,000). Again, travelling over the ten years between 1860 and 1870, we find that at the latter date the foreigners amounted to 5,567,000, or one-seventh of the total population, while of the insane (37,432), no less than one-third were returned as foreigners. Lastly, taking the period from 1870 to 1880, during which praiseworthy efforts have been made to alleviate the condition of the insane in almshouses, we find that at the latter date there remained about one-seventh of the population foreigners. As we have already stated the census of 1880 showed the number of insane to be 91,959. Well, no fewer than 26,346, or between one-fourth and one-third, were not American born. In other words, 13·33 per cent. of the general population—that is to say, the imported element—produced 28·75 per cent. of so-called American lunacy. Stated in another form, if the native Americans*

* Including the coloured population, among whom the ratio of insane is as 1 to 1,097. As is well known, idiocy rather than insanity occurs among the negroes.

alone are considered, there is 1 insane person to every 662 of the population; while the proportion among the foreigners alone is as high as 1 in 250. To show that the liability to insanity of foreigners in the States is greater than that of the native population, and that therefore the Americans are disproportionately weighted with this terrible burden, it may be added that if the average native white proportion of insanity were the rule, the number of insane in the United States in 1880 would have been 81,158 instead of 91,959.*

The force of the present contention would be much strengthened, were we to include the hereditary influence exerted by the foreign class—one which does not appear in any statistical tables, for the insanity which occurs among the children of mixed marriages will be merged in that of the native population: It is hardly necessary to say that the Americans, while they are becoming alive to the heavy burdens inflicted upon them by immigration in the form of insanity, pauperism and crime, are not blinded by these facts to the great balance of gain which is theirs. They feel that they must arouse themselves to keep out the scum and dregs of European populations, and that the check must be made in the first instance at the port of departure; also, that unsuitable immigrants should be forbidden to land by the control of quarantine in charge of medical experts. A bureau of health and immigration should, it is proposed, have agents abroad attached to consular offices, and agents in the ports of the States to carry out the powers granted them by Congress. Dr. Foster Pratt, who in his excellent paper makes these and other proposals, writes in no bitter spirit in regard to immigration, and would by no means wish to tax the immigrants to pay the expense involved.†

I will only add to my already long communication that if I have not hesitated to speak freely of any shortcomings, as they seem to me, in the arrangements or administration of the American asylums, I entertain the hope that their virtues rather than their failings will attract our notice, and that we shall strive to emulate their example in everything in which they have succeeded in adding to the convenient appliances of asylums, or in increasing the comfort or happiness of the patients confined therein. Fresh from the unstinted hospitality and attention received from American physicians and others, I would express the desire that they may always receive a hearty welcome from the medical superintendents of English asylums, when they visit our shores.

* These figures are given by Dr. Foster Pratt in a Paper read before the American Public Health Association in 1883, and are based on the last Census. Of the 91,959 insane, no less than 83,665 are paupers, of whom 22,961 are foreign-born.

† At the present time all aliens arriving at any port in the United States must pay a tax of 50 cents, which goes towards the expenses incurred on the arrival of distressed immigrants, but does not help the interior States to care for them when they become insane.

2. *English Retrospect.*

Asylum Reports for 1883.

Abergavenny.—After a service of twenty-five years, it has been necessary for Dr. M'Cullough to resign on account of ill-health. His Visitors paid a very high tribute to his ability and devotion to work, and they assigned him a retiring allowance of £730 a-year. Dr. Glendinning has been promoted to be medical superintendent.

The additions and alterations have been completed, and are now in use. These include accommodation for 320 patients, a chapel to seat 508, a dining hall for 500, an administrative block, and large additions to the laundry.

Barnwood House.—This hospital is quite full, and 60 patients were refused admission during the year. "The Committee believe that the reputation the institution now enjoys is such that very large additions to the existing accommodation would be immediately filled. It is doubtful, however, how far such increase would be expedient. Hitherto the patients in Barnwood House have been so comparatively limited that it has been possible for the superintendent to be in continual intercourse with them, and they have been treated more as members of a large family than as inmates of an institution." It is proposed, however, to increase the accommodation, chiefly for wealthier patients, so that more extended charity may be dispensed to the poorer class. During last year 61 patients received assistance. Five were maintained gratuitously.

There is every indication that this asylum is most successfully directed.

Bedford, Hertford, and Huntingdon.—The Visitors report that "the increase in the number of patients under treatment in asylums has been ascribed by her Majesty's Commissioners in Lunacy as the result, during late years, of the Parliamentary grant of 4s. paid to unions for each patient in a county asylum, through it having induced the Guardians to send cases to an asylum which might have been treated in workhouses. This view is not generally adopted by asylum authorities, and certainly does not correspond with the opinion formed by your Committee, after a careful enquiry in the matter. There have been certain cases which, in the opinion of the Medical Superintendent, might have been retained in the workhouse, but these are exceptional. It should also be taken into consideration that the required accommodation does not exist in workhouses for the proper treatment of other than the very harmless cases of lunatics; and even cases which are often pointed out as such as might be retained in the workhouse, as being imbecile from age, &c., are often of a very troublesome class, and require a great deal of care and attention. It has been cited that when a certain number of apparently harmless cases had been trans-

ferred from an asylum to a workhouse they had soon become so much deteriorated in health and habits from the absence of that careful treatment bestowed upon them in an asylum as to become quite unmanageable. The increase might more properly be ascribed to the change in public opinion with respect to the treatment received in asylums, and thus creating a desire to send those to an asylum who would otherwise be treated by friends or perhaps left totally neglected, and also to the decrease in the death-rate."

A slight fire broke out in one of the water towers through an accumulation of soot being ignited by a spark from a chimney. Through the energy and bravery of the staff it was speedily extinguished.

An unexpected attack was made by a patient on an attendant, by striking him on the head with a mallet, causing fracture of the skull. The attendant was not expected to survive, but he ultimately recovered, and has been pensioned.

Berkshire.—In consequence of the occurrence of an abnormal number of cases of diarrhoea and erysipelas, the drainage is being examined, and it is proposed to ventilate it. The water was examined, and found very satisfactory.

Dr. Gilland's report is full and satisfactory. It contains an extract from the Commissioners' report, but that document is not given in full. This, we think, is a mistake.

The attendants and servants are now provided with uniform, but the changes in the staff continue numerous.

Birmingham, Winson Green.—Here we would again note the absence of the Commissioners' report.

Out of a total of 329 admissions 55 were suffering from epilepsy, 31 from general paralysis, five from phthisis, and 29 from other active organic diseases.

Birmingham, Rubery Hill.—The proportion of epileptics appears to be unusually large. Of 502 patients no fewer than 176 are epileptic. The total deaths for the year were 61, and of these 28 were due to epilepsy. Yet only one death was attributed to general paralysis.

Much attention is said to be paid to the exercise of the patients beyond the asylum grounds. All whose bodily health permits it, enjoy this privilege.

It is reported that a scheme has been prepared and sanctioned for providing accommodation on the estate for the burial of pauper lunatics dying in the asylum and not removed by their friends. This, though a very common arrangement, is, we think, an unfortunate one. There is no more reason for an asylum than for a hospital having a special grave-yard, and we are strongly of opinion that it is much better in every respect that the pauper lunatic should find a resting place in the parish churchyard rather than in some obscure corner of the asylum estate.

A clinical assistant has been appointed.

Bristol.—Although about ten acres have been added to the estate,

it is still small for the size of the asylum. The average number resident was 433. The Commissioners advise a further purchase of land before they can recommend any enlargement of the building.

Dr. Thompson has given way on the subject of continuous night supervision of epileptics, and the Commissioners report, with much satisfaction, that it is to be introduced immediately. In this matter we are sure that Dr. Thompson has done right in yielding, and he will find even in such things that discretion is the better part of valour.

The staff of attendants and nurses appears to be small. There are only 14 men and 15 women for day duty. From these must be deducted say one of each sex per day on leave or sick.

The beer question is now nearly exhausted, and we may take farewell of it by reproducing Dr. Thompson's remarks. He says: "On the 1st September last, in accordance with the resolution of the Visitors, beer ceased to be an article of ordinary diet. This change was not made in haste, but after much deliberation. From every point of view it has been beneficial. The beer given was much better than that usually supplied in asylums, and I had long maintained that it had no dietetic value whatever, or, if it had any, that that value was counterbalanced by the deleterious effect, moral and physical, which it had. The patients drank the ordinary amount allowed as a matter of course, and were not benefited by it. Those who were expected to do work got an extra allowance, and were all the more discontented with their lot. No extra work could be got out of anybody unless extra beer was allowed. The nurses and female servants seldom drank it, but received no compensation for their abstinence; while the male attendants were often the worse for what they had consumed. It is only fair to these to say, however, that they had frequently expressed a desire to be allowed money instead of beer; but I need hardly say that there was a difficulty in that matter so long as beer was sent to the wards. Now each paid man receives £4 and each paid woman £2 per annum in lieu of the allowance of beer, and insobriety is now very conspicuous by its absence."

Cambridge.—The Visitors express their regret at Dr. Bacon's death, and voted an addition to a fund raised by the staff to place a window in the chapel to his memory. Poor Dr. Bacon! Now that he is dead he is greatly missed, though whilst he was alive he had a sad time at the hands of his Visitors, who interfered in the pettiest details of the management, and seemed rather to retard than facilitate official business.

The report to Quarter Sessions should include only important matters; this is an almost universal rule, but Cambridge is an amusing exception. Everything is put in it; nothing is too minute or mean. A special paragraph is devoted to the announcement of a hall porter being appointed *vice* so-and-so resigned. This servant's appointment is mentioned as a change in the staff of officers, and

comes immediately after the record of Mr. Rogers' appointment as Medical Superintendent. From this it is quite clear that the Visitors of the Fulbourn Asylum are determined at every risk to exalt the dignity of the Medical Superintendent, and it is not improbable that they take off their hats to the hall porter.

The Commissioners report that they observe with much satisfaction that several subjects formerly giving occasion for adverse comment have been remedied. They call attention to the fact that there is no system of daily extended exercise beyond the airing-courts.

Carmarthen.—Plans for a large detached chapel are in preparation. When the building is used for worship both officers and patients will appreciate the advantage—that is if the building is handsome and genuinely ecclesiastical in character, and the services musical and well rendered.

The following paragraph would seem to indicate that the views of the Commissioners have undergone some modification in regard to restraint. *Inter alia* they report : “The employment of seclusion or use of mechanical restraint is not recorded in any case, but we saw two patients in whose case mechanical restraint was only avoided by manual force—one woman was kept in bed by a nurse sitting in the bed, having the patient's head between her knees and another nurse holding her arms down to her side ; whilst another woman was struggling with one nurse who held her arms for a time, but she ultimately broke away, and then was kept down by two nurses holding her arms on either side of a bed. We give no opinion as to the advisability of mechanical restraint in either of these cases, but we wish to state that cases must often arise when restraint by means of the jacket would be proper, as tending not only to irritate the patient less, but also as rendering bodily injury to the patient more unlikely.” Shade of Conolly !

If we may be permitted to make a further remark on this paragraph, it is this—that for one case in which restraint is necessary there will be a hundred where rest in bed or seclusion will be beneficial. Although a patient's arms are tied up, his legs are free, and he can get into a lot of mischief ; but if he is allowed to remain in bed whilst excited, the causes of irritation will be mostly absent.

A second assistant medical officer has been appointed. None but infirm and feeble patients are denied exercise beyond the airing courts. The men are frequently taken for walks in the country ; but Dr. Harder cannot manage to take the women in like manner, as they are troubled by a number of idle loafers who amuse themselves by shouting out ribald remarks. This is an annoyance which need not last long. The police should be informed of the state of affairs, and they will prosecute a few for annoying the patients, and the nuisance will speedily disappear.

Cheshire, Chester.—Fish is now given for dinner once a week, and it is stated that the patients enjoy the meal.

The Commissioners report : " We were sorry to see that no plants or shrubs were in the female airing-courts, and Dr. Davidson told us that he had tried often to get the patients to take care of the plants ; but as soon as they were planted they were uprooted. We have so often seen the continued efforts of medical superintendents, even in asylums where a worse class of patients are collected, successful, that we hope renewed exertions will be made in this matter, as the female airing-courts contrast unfavourably with those on the male side."

The true secret for allowing the shrubs to grow is to keep the women out of the airing-courts. This we say in earnest, as we firmly believe female patients should exercise in the grounds or beyond them. The very worst patient, if fit to go out at all, can be sent into the grounds. Women rapidly degrade if allowed to loiter about an airing-court. There is nothing to interest, nothing to amuse them, so they take to working mischief, for Satan finds some mischief still, &c.

It would appear that very few men are taken beyond the airing-courts for exercise.

Cheshire, Macclesfield.—In this report Dr. Deas takes farewell of his visitors after a service of nearly fifteen years.

In this asylum all patients physically able have extended exercise beyond the airing-courts.

Cornwall.—This asylum is quite full, and the visitors have been obliged to place restrictions on the admission of fresh cases. This is very much to be regretted. The new buildings are making satisfactory progress.

Denbigh.—A great many structural alterations and additions have lately been made. It is feared that at no distant time it will be absolutely necessary to increase the accommodation.

Erysipelas attacked several patients on the female side, and two died. In the same wards cases of typhoid had previously occurred. The cause was found in a cesspool into which the sewage of these wards flowed, and which had been neglected.

Derby.—It will be necessary to build accommodation for female patients unless some of the chronic harmless cases can be removed to workhouses or boarded with their relatives. Relative to such patients Dr. Lindsay says : " In the last Annual Report for 1882, at page 13, I pointed out that our experience of the removal of harmless chronic and imbecile male patients from the asylum to workhouses had not been satisfactory (an experience not peculiar to Derbyshire, but agreeing with the general experience in Nottinghamshire, Staffordshire, Lincolnshire, Lancashire, Yorkshire, Northamptonshire, Essex, Hants, Devonshire, and many other counties), that the Committee had not received the assistance from Boards of Guardians and workhouse authorities that might have been expected, in their own interests and in the interest of the ratepayers, and that relief to the

asylum from this source cannot be relied on. Some relief to the asylum accommodation might perhaps be obtained by boarding out suitable chronic and imbecile cases with relatives and friends, or other proper custodians, provided the Guardians would make them some money allowance for their maintenance—an allowance less than the asylum charge.

“As an exception to the general experience, it may be stated that by these means relief has been obtained at the Sussex Asylum, the Guardians readily receiving such cases into the workhouses, and granting an allowance not exceeding 5s. per week to the custodians of boarded-out cases.

“But the difficulty in obtaining relief to the accommodation from these sources may be threefold. In the first place, to overcome the indisposition on the part of the Guardians and workhouse authorities to receive and keep in workhouses harmless chronic and imbecile cases sent from the asylum; in the second place, to induce the Guardians to encourage the boarding-out system by contributing towards the patients’ maintenance when boarded out; and, in the third place, to find proper custodians who are willing to undertake the care of such patients for a moderate sum.

“There might, probably, be other difficulties connected with their supervision when boarded out, and with their return to the asylum if proved unfit cases for such boarding out.”

For remarks on the beer question and the use of stimulants in asylums, we would especially refer to Dr. Lindsay’s report.

Devon.—Extensive drainage work has been completed, and the sewage is distributed over the farm with very profitable results. Alterations and additions are to be made to the laundry at an estimated cost of £2,000, and £1,500 for machinery.

A second assistant medical officer has been appointed.

No fewer than five women were discharged as not insane. Relative to these cases Dr. Saunders says :—

“There is little to note among the admissions, except that five patients were discharged, not having been found insane; the year before there were seven. It is difficult to say how and why these patients found their way to the asylum; but it is fair presumptive evidence that they were sent on insufficient grounds, as, with two exceptions, they have not been re-admitted on fresh certificates. Of these two, one is a prostitute of low degree, mentally and physically, who from drunkenness or disorderly conduct is sent to prison, and from thence gets transferred to the asylum as a criminal lunatic; the other is an ‘incorrigible rogue and vagabond,’ who has been some fifty times in gaol, was sent by a philanthropic society to New Zealand; but the amiable bishop, in pity for the natives, transhipped her to her native country. This is not the place to discuss the abstract question of the difference between crime, vice, and insanity; but your Superintendent ventures to express his opinion that county asylums were not originally intended for patients of this class.”

Dr. Saunders records a good example of the value of the monthly weighing of patients. A change in the diet was made, and in a month 75 per cent. had lost weight. We cannot too strongly recommend the monthly weighing of patients to all superintendents who have not adopted it, if there are any such. Its advantages are obvious.

Dorset.—This asylum is also full. The Visitors report that although they have attempted to relieve the wards by sending harmless cases to workhouses, their efforts have not hitherto met with much success.

In answer to the Commissioners, Dr. Symes stated that four males and four females might be treated in special lunatic wards in workhouses; 21 and 35 respectively being suitable for infirmary wards with paid nurses; and five males and nine females requiring no more care than can be obtained in ordinary workhouse wards. In making this return he guarded himself by stating that everything would depend on the arrangements actually made in the union houses whether his list would require modification or not. He adds—"No doubt there are now many and great difficulties existing to prevent patients being satisfactorily cared for in unions amongst the ordinary paupers; yet, on mature reflection, in houses where there is plenty of room, there ought not to be any obstacle which could not be easily overcome. Increased cost to the union must of necessity be, for a time, the inevitable result, but few patients would then be in the asylum, where the costs are necessarily higher; and another important advantage would accrue, that all recent and oftentimes curable cases would be admitted here, with, it is to be hoped, every fair chance of recovery and early return home. This is an advantage which cannot be over-estimated."

Even granting that the accommodation is sufficient in workhouses, superintendents should make enquiries as to the employment, exercise, amusement, general treatment, &c., &c., of paupers therein.

Dundee.—It is to be regretted that the financial condition of this asylum continues to be highly unsatisfactory. In answer to an appeal for help, subscriptions to the amount of £2,192 have been received and £1,550 promised. The sum received enabled the Directors to declare a dividend of 6s. Various changes have been made in the hope of reducing the working expenses of the asylum.

The reports of the Commissioners are not given.

Durham (1882).—Relative to the insane in workhouses the following paragraph in Dr. Smith's report is valuable:—

"It may be interesting to note that Gateshead Union, with a population of 223 insane persons, sent 60 patients, while Sunderland, with an insane population of 301, sent only 40. Further, that Gateshead Workhouse contained on the 1st January 29 insane persons, or an increase on the previous year of three; while Sunderland Union had 93, or an increase of 23; consequently it is not to be wondered at that while Gateshead shows a recovery-rate of almost 14 per cent., calculated on the total number of insane persons in the Union, Sunderland shows only 9 per cent."

In their report the Commissioners note that one woman had died of typhoid fever, and that this disease had attacked 22 women and five nurses. The cause was considered to be due to the fact that someone had placed a cap on the top of the ventilating pipe from the closet. This has been remedied, and the fever has stopped. The whole of the patients affected occupied contiguous wards.

Durham (1883).—A new chapel is in course of construction. It is estimated to cost £3,380, or about £5 per sitting. Two cases of small-pox occurred, the disease having been imported by the friends of patients.

Earlswood.—The following paragraph relative to epileptic children draws attention to the lot of an unhappy class for whom little is done. It is with pleasure that we observe that they are received at Earlswood, and that efforts, though not very successful, are made for their education. Even though they received no benefit in that direction, it is evident that they are more favourably placed in such an institution than with insane adults in an ordinary asylum.

Dr. Cobbold writes :—"One-fourth of our inmates are the subjects of epilepsy. When the decision was originally taken to admit certain cases of epilepsy to the benefits of the institution, it was considered that some such cases were curable, or at least improvable. So far as it relates to patients eligible for admission to Earlswood, this is true only with regard to cases of recent occurrence in young subjects. I gladly welcome such cases here, but they are very rare. Epilepsy in children tends to be associated with idiocy or varying degrees of imbecility. Later in life, however, the mental condition most often seen as a result of chronic epilepsy is one of dementia with liability to paroxysms of maniacal excitement. Such cases can only be properly treated in the wards of a lunatic asylum. Any patient becoming thus dangerous would, of course, be removed from here as soon as the necessary forms could be complied with. Not a few of our inmates, however, who were admitted here years ago as epileptic children are now upon the borderland of the condition indicated.

Edinburgh, Morningside.—As usual, this report is full of interest—an admirable record of excellent work done. Strong efforts continue to be made to limit the number of pauper patients and to extend the benefits of the institution to the poorer middle classes.

The following interesting cases are recorded :—"The delusions of insane people often come to be looked on as not so absurd after all by people counted sane. One of our patients had possessed so much native vigour of mind that she had persuaded a sane sister, with whom she lived, that her own delusions were true, and not fancies at all. For instance, the insane sister believed that an imaginary Donald McKechnie came up through the floor, or through the key-hole, and stole her sugar, of which, poor soul, she hadn't a great store. And she reiterated this so often and so earnestly that the sane sister came to believe it too, though she admitted McKechnie was so clever a thief that she had never seen him.

"A female patient nearly succeeded in committing suicide by transfixing the heart with a long needle. Being very suicidal, she was under constant supervision. Just as she went to bed one night she suddenly became very ill. She was seen in a minute or two by a medical officer, who found that with the long pin she had just taken out of her cap she had transfixed her heart through and through. She had felt for the point where its beat was most directly felt, and had done this so quietly that her attendants, though within two yards of her, looking at her, had not noticed the act. If a medical officer had not been at hand she certainly would have died within a few minutes. As it was, she was none the worse after a few days."

Having completed 10 years' work at Morningside, Dr. Clouston has examined the results medically and financially. In these 10 years the place has been almost rebuilt and completely remodelled, and it has been possible to defray most of the cost, some £68,000, out of ordinary income. In comparing the medical statistics with those of an equal period at Garlands Asylum several interesting points are brought out, but for these we must refer to the report.

Life and Kinross.—As the disposal of the harmless and incurable insane is a question of the greatest importance, we make no apology for reproducing the following paragraph from Dr. Turnbull's report. We are inclined to attach importance to his statements, he being young in office as superintendent, and new to the boarding-out system.

Concerning the 21 patients boarded out during the year he says.—
"To what was said in last year's report I may be allowed to add that further experience has confirmed my belief in the great utility of the boarding-out system. In a certain number of cases the trial does not prove successful, because in insanity there is very markedly a tendency to relapse into periodic exacerbations, more or less acute, of the symptoms; and when such relapses occur it may be necessary to have recourse to asylum treatment. Or the choice of patients or of guardians may not have been happily made. Of the five cases sent back last year, one was, after a short trial, considered unsuitable, from her age and other circumstances, for remaining under private care. Another had to be replaced in the asylum on account of his persistent habit of wandering away from his guardian's home. A third, when boarded out, showed violent tendencies, of which he had given no sign while in the asylum. In the remaining two an attack of acute excitement came on, rendering asylum control again necessary. But in the great majority of cases the results are very gratifying. Through the kindness of Dr. Fraser, Deputy-Commissioner in Lunacy, I had the opportunity at different times, of seeing most of the cases that were sent out during 1882. In nearly all of them the care and guardianship were satisfactory; and when such was not the case steps were at once taken for removal to other guardianship. In a large number of cases the change of surroundings and mode of life, with the

consequent individualization, had had a distinctly beneficial effect on the mental condition. The patients were brighter and more contented, showed a more active interest in the concerns of their daily life, and occupied themselves more usefully and steadily. And with the development of these healthy characteristics their insane proclivities had become less prominent. One case had improved so much that the guardian said there was nothing wrong with her mind at all. Many of the patients had likewise benefited distinctly in bodily health by the change."

The following paragraph from Dr. Mitchell's report is highly important, dealing, as it does, with the results to the patients who remain in the asylum after the discharge of the best and useful patients to private dwellings :—

"It is satisfactory to be able to record further that the removal of quiet and useful patients has not led to any diminution of the number either of men or women who are actively engaged in profitable and healthy work. It appears, indeed, that the presence of a large number of patients in an asylum who are easily induced to engage in useful occupations, and who are able to undertake the whole work of the institution, may, and does, lead to some weakening of the efforts to get those patients to work who are less willing and seemingly less able to do so. The laundry experience here seems to prove this, the washers and dressers being as numerous and efficient as they ever were. The place of those long employed in the laundry, and now gone, has been supplied by patients who were formerly accepted either as unfit to engage in such work or as incapable of being induced to engage in it. At no visit made to this asylum were so many women found actively employed in the laundry; and it was stated that the successful efforts to get unpromising patients to work had been productive of so much good to them that it was felt to be very desirable to have a still further increase of their number. Accordingly it is strongly recommended that an additional line of tubs be erected on the east side of the wash-house."

As to the numbers actually employed, it would appear from Dr. Sibbald's report that of 164 men and 175 women resident, there were 132 and 127 employed. Of these, 72 men were employed in active outdoor work, and 29 women in the laundry.

Friends' Retreat.—The estate has been increased by the purchase of three fields, at a cost of £7,650. This admirable institution appears to be doing a great charitable work by affording assistance to patients of the poorer middle classes. The Commissioners remark :—"It is satisfactory to notice that though structural improvements continue to be observed by the various members of our Board at each succeeding visit, we never have to call attention to a reduction in the number of patients received here. It runs much below the cost of maintenance, but this hospital continues to be really a charitable institution for the insane, though it is not called by any such title."

Glamorgan.—Dr. Pringle is to be congratulated on the substantial increase of £300 to his salary. It is not every day that such a handsome addition is made to the income of a medical superintendent.

Most extensive alterations and additions to the buildings are in progress, at an estimated cost of £62,800.

(*To be Continued.*)

3. *Retrospect of Mental Philosophy.*

By B. F. C. COSTELLOE, B.Sc.M.A.

"Revue Philosophique," Nos. 85-108. (Jan., 1883—Jan., 1885.)

In the Retrospect which appeared in April, 1883, we promised to give some account of the "Revue" for the early months of that year, in which, as it happened, there were certain articles of much importance to the psychological student. The January number opened with the third instalment of M. Ch. Lévêque's discussion of "The Musical Æsthetics of France," dealing with "The Psychology of the Orchestra and of Symphony," which is very fresh and attractive. He begins by recalling the general conclusion to which his researches of the January and March numbers of 1882 had led him—that each instrument *is* a kind of *quasi-human voice*. This, he maintains, is not a metaphor, but a scientific fact, confirmed for example by the work of Helmholtz, "A musical instrument is a voice singing without words; and a voice singing without articulate words is simply a musical instrument." In confirmation he quotes from a criticism of M. Blaze de Bury on a passage of Weber's "Euryanthe." "You call that an orchestra, Monsieur: you are wrong: it is the voice of elements in anger." And he goes on to cite some interesting passages of Berlioz. Instrumental music is an "abstraction" of the music, or some part of it, from the words, analogous to humming or whistling; and by consequence it has a "psychology" of its own. It is an artificial larynx, in fact. Having established this, with much of that literary discursiveness natural to a French essayist, he passes to the history and character of the Symphony, noting, to begin with, that its three main sections, the *allegro*, *andante*, and *finale*, are descended directly from the three sorts of vocal music favoured by the Italian singers of the time, the *aria*, the *cavatina*, and the *rondo*. From this basis, with the aid of his already established conception of the orchestra as a chorus of artificial voices, he leads up to the view that the true criticism of a symphony is not the ordinary disquisition on the technical skill by which certain rhythms and phases are complicated and interwoven in the orthodox compositional form, but that which in this country is associated with the school of Wagner—the criticism, namely which sees in the instrumental voices a story, a movement of emotions

and passions, a lyrical or dramatic presentment of a phase of human life. He gives as an illustration the greater part of a curious translation into words of one of Haydn's Symphonies, written 50 years before Berlioz' "A Travers Chants" astonished the classicists, by a certain Dr Monigny. One of the curious questions that arise, of course, in the inquiry, is whether it is true, as the technical musicians often say, that an air or a musical passage might equally well be wedded to utterly different words, or suggest to the hearer utterly discordant senses. To refute this the essayist again cites Berlioz, who, in the "Grotesques de la Musique," calls such a theory, "the atheism of expression," and offers an experimental refutation by asking his readers "to sing the words of the Marseillaise to the air of 'Grâce de Dieu.'" Curiously enough, although the whole controversy has the closest relation to the discussion which raged so fiercely in musical circles when Wagner's "Music of the Future" was first made popular, M. Lévêque does not even mention Wagner's name throughout the article.

After this curious but suggestive paper, a M. Séailles follows with one of his studies of contemporary philosophic writers, concerning M. Jules Lachelier, the little known neo-kantian professor of the Ecole Normale. Our readers will doubtless pass on without hesitation to the following important contribution of 33 pages on the "Criminal Statistics of the Past Half-century," by G. Tarde. It is an analysis, by one who has deeply studied the moral and social conditions of modern society, of the tableau presented in the "Rapport" on the comparative criminal statistics of the period 1830-1880, fully equipped with tables, charts, and curves, which has lately been officially published as a blue-book of the French Ministry of Justice. The tone of the report, as M. Tarde remarks at the outset, is by no means optimist; and oddly enough, one of the most striking points brought out by it is the tendency of political revolutions to accentuate the curve of crime—a point of statistical induction which our neighbours have unhappily only too ample opportunities of testing. Another fact, equally characteristic, comes out also in the first page: that the number of adultery prosecutions in 1880 was *nine times* that for 1826. The dangers of political disintegration are serious enough; but in face of so rapid an increase of social decay within the family itself, on which all society must needs rest, it is indeed time to bethink ourselves about the future.

In the limits of a Retrospect it is impossible to do justice to the deeply interesting and important facts brought out in these pregnant pages; but we make no apology, seeing the immediate importance of the recidivist question, for devoting some space to their discussion. Beginning with the common-place refuge of optimists—the theory that in the general increase of crime it is the less serious offences that have multiplied, whereas the felonies have decreased—he shows, with horrible convincingness, that this is a deceptive result, brought about by the tendency in recent years (since 1855 in France) to

reduce the less grave felonies into misdemeanours, with a view to the simplification of procedure. The French tribunals have been particularly prone to this kind of leniency in cases of "vol qualifié," and "attentats à la pudeur contre adultes." The latter were, since 1855, reduced where possible to "outrage public à la pudeur." Up to 1855 the "attentats" increase in the Judicial Tables steadily. After that date they suddenly decrease; and as suddenly the general rise of "outrages" experiences an obvious and startling acceleration. But even apart from this question of transfer, the growth of "outrages à la pudeur" is itself appalling. In 1830 they stood at 302; in 1880 they were 2,572. If anything more is wanted to convince the most sceptic of the march of moral ruin in France, it will be found in the "attentats à la pudeur des enfants," which, forming a class apart, are free from the influence of accidental changes of police procedure. In 1830 they were 136; in 1880 they were 809. It is to be remembered, of course, in comparing these figures with our own, that France has no excuse to make, unhappily, on the score of increase of population. The growth of the nation in the half-century was only about 10 per cent.

There is one very curious fact which merits notice, though it is probably special to France. The "determining motive" in murderous crimes was put in 1826-30 as "cupidité" in 13 per cent. of cases, and "amour" in the same percentage exactly; but in 1876-80 "cupidité" has mounted up to 22 per cent., and "amour" has fallen to 8 per cent. As M. Tarde quaintly observes, it is not likely that the force of either love or hate (which has diminished also) should have grown less in the last half-century; "especially as the annual number of suicides for love has remained nearly the same for 40 years, whereas suicides by reason of reverses of fortune have risen markedly, suicides under physical suffering have quadrupled, and suicides through drink have quintupled."

After an interesting refutation of the specious, but absurdly misleading, optimism of the Italian statistician Poletti (whose answer is published in the "Revue" for March), M. Tarde proceeds to the question of causes and remedies. Noticing the specific evil of France—the high proportion and rapid increase of habitual criminals (*récidivistes*)—he maintains ingeniously that the increase of means of communication is one great cause of the augmentation of crime in civilized societies. Indeed, he regards a crime as especially dangerous, not in itself, but in the fact that it constitutes a breach of that *moral habit* which is the natural state of a man born and trained in any decent form of social order; and that it becomes thereby a starting-point from which the wrongdoer is led to copy himself, and to be an evil example to all about him. One important phase of the same line of argument is that the "déclassement" resulting from the crime is a fertile source of fresh crime. Moral society is respectable, but inhospitable. The little Alsatia of the criminal classes is always ready to

welcome the recruit. Precisely as with moral failures, the seduced tend almost inevitably to prostitution, *because* society is closed against them. So, with crime, as says the blue-book for 1878, "the relapses of prisoners happen most commonly in the first months after their release—whence the conclusion that the difficulty of the "reclassement" of released prisoners is the cause of the rise of habitual crime." If this be so, as M. Tarde insists, it follows that even this age, which pins its faith to reliance on self-interest as the sole motive of life, must recognise the need of charitable and philanthropic machinery to repair the gaps in the social structure. "The growing evil," he holds, "is imputable neither to the police, nor to the tribunals, nor to civilization, nor to the peculiarities of the criminal law; but probably to the checking of the charitable instincts and the rise of revolutionary passions" during this epoch. As to the further influence of the decline of religious belief, the increase of wealth and industrial labour, the improvement of education, &c., he has many pregnant things to say, but we have not space to follow him here. He does not think much, and neither does the official reporter, of the moralizing effect of primary education, of which we used to hear so much a few years back. "Madness and suicide," he says, "augment visibly in a degree parallel to the progress of education; but we can see nowhere any similar restrictive effect on crime. A separate table in the official report, shows that the departments where the proportion of illiterate persons is highest are far from being those where the number of accused persons is greatest in proportion to the whole population." He does believe, apparently on slender grounds, that *higher* education is moralizing, and that the most effective side of it is the "higher culture" of the æsthetic qualities—a very poor buttress to rely on surely, in a society that is going bodily to pieces. But we must advise our readers to consult M. Tarde for themselves; the trouble will be well repaid.

After an exchange of interesting notes between M. Tannery and M. A. Fouillée on the recent mechanical and mathematical speculations on the possibility of freewill considered in the latter's essay in December, there follows a most appreciative and clearly-written account of "Kant and his English Critics"—a work in which Professor Watson, of Canada, an eminent pupil of the new school of Anglo-German metaphysics, has reviewed the Kantian position, and attacked the ruling Spencer-and-Mill psychology of the fashionable English school. The critic, Victor Brochard, has made a thorough and appreciative study of the book, and his account of it will be of interest to many who may not care to strain their mental energies to the reading of the original. M. A. Espinas follows with a short notice of Romanes' "Animal Intelligence," which, however, he does little but praise. "Mind" and the "Journal of Speculative Philosophy" are noticed; and an excellent number of the "Revue" closes with a letter from M. Dauriac upon some points raised by M.

Hérault's remarks in September, as to the "mémoire de l'intonation," in which he supports, amongst other things, the curious notion that there is a natural association between tones and colours—reminding one of the blind patient who said that he understood by red "something like the sound of a trumpet."

The February "Revue" was also valuable, but less striking than its predecessor. M. Bouillier opens with a paper on "Moral Responsibility in Dreams," a subject which, as he remarks, the casuistic fathers treated of, though it has escaped so far the attentive pen of the modern psychologist. M. Ribot discourses on the "Anéantissement de la Volonté;" but though the paper is not without its value, and may interest many of our readers, it is difficult to do more than refer them to the original, which is lengthy, and hard to condense into any useful summary. It is, of course, an endeavour to draw from pathological states of mind some indications as to the philosophy of normal volition. The French translation of Darwin's "Earth Worms" is also reviewed. The March number commenced with an admirable essay by C. Richet on "Personality and Memory in Somnambulism," which must also be read for itself, and will well repay the trouble.

The May "Revue" of 1883 was chiefly notable for an analysis of Dr. Charles Richet's "Physiology of the Muscles and Nerves," and of Wallace's edition of "Aristotle's Psychology." There are also a couple of interesting notes on the time required in olfactory perception, and a study on Parmenides by M. Dauriac. In June, M. Alfred Fouillée discoursed at some length upon the subject of Free Will, and upon the true nature of "Contingency" as applied to future events, without arriving at any clearer light upon that difficult subject. M. Tarde contributes an important note on Italian Criminal Statistics, and M. Beaunis carries further his researches on the comparative times of reaction for different sensations. In July, M. Fouillée returned to the question of Liberty and Causality, and M. Lévêque pursued his interesting studies in musical philosophy by writing on the range and psychological limits of orchestral expression. Amongst the book notices was one of a French translation of Zeller's History of Greek Philosophy, of a new edition of Schwegler's Greek Philosophy, and of Kehrbach's collected works of Herbart.

The August number was an important one. It opened with an article by E. von Hartmann on the School of Schopenhauer, and it contained interesting notes by M. Th. Ribot on the "Psychology of Movements," and by M. J. Delbœuf. The article on Pessimism can hardly be here dealt with at length, but it merits careful attention. In September, the opening essay was on the very interesting subject of the relation of Greek Medicine to Greek Philosophy, by E. Chauvet. It is an admirable study of 24 pages, full of facts concerning not only the general history of the philosophico-medical schools leading up to Galen and Hippocrates, but also the contents and general philosophy of the various important writers, so far as they

are still preserved to us. No more interesting or useful article has appeared in the recent numbers of the "*Revue*," for it supplies a felt want in the history of Greek thought, and it clears up an important chapter in the too-little studied history of early medicine.

The issue of October, 1883, was unusually valuable. Commencing with a paper by M. Delbœuf, entitled "*La Matière brute et la Matière vivante*" (of which it is not too much to say that it states with admirable clearness one side of that scientific idealism which is rapidly replacing the early and crude materialism of a few years ago), it contains also the first part of a curious sketch, by M. Tarde, of the connection between an archæological and a statistical study of human history; a valuable note by M. Paulhan upon sensory images, in answer to the recent theories of Stricker; an analysis of E. von Hartmann's "*Religion des Geistes*," and of Buccola's "*Legge del tempo nei fenomeni psichici*;" as well as notices of the Butler, Hamilton, Kant, and Fichte series among the philosophical classics for English readers and of the Proceedings of the Society for Psychical Research. In November, 1883, M. Georges Lyon contributed a review of the late Prof. W. K. Clifford's position under the title of "*Monisme en Angleterre*;" and there were reviews of Galton's "*Inquiries into Human Faculty and its Development*," and of Dr. Jules Simon's translation of Braid's *Treatise on Hypnotism*, with an additional chapter written by the author in 1860. December brought out an exhaustive paper by H. Marion on Bari's Biography of James Mill; a paper on cerebral localisations and evolution; an essay by Mr. James Sully on Moral Development, and another by M. Ribot on the "*Organic Conditions of Personality*," each of which would claim more space than can be given to them here.

The first number of 1884, besides another of M. Lévêque's pleasant papers on Musical Psychology already referred to, contained Herbert Spencer's chapter of the "*Principles of Sociology*," which he heads "*The Past and the Future of Religion*," followed by an important note of Dr. E. Gley on recent investigations into the aberrations of the sexual instinct. In February, 1884, M. Guyan was daring enough to enter upon "*The Æsthetics of Modern Verse*" (finished by him in March), but the number was not important. In March there appeared another musical study by M. Lechalas, but the interest of the "*Revue*" lay in the notices of M. de Quatrefage's "*Fossil and Savage Men*," of Bastian's Psychology, of Leslie Stephens' Science of Ethics, and of Cesca's theory of special localizations.

The issues of April and May were less remarkable. In June M. G. Tarde published an interesting study entitled "*Darwinism, Natural and Social*," the main point of which is that societies are much less complex and inexplicable than living organisms, because we know the units of society, but we cannot say we know the ways and capacities of a cell. M. Féré had also an important paper belonging strictly to psychical medicine, entitled "*Troubles de l'usage des Signes*," in-

cluding aphasia, agraphia, verbal amnesia, verbal deafness, and verbal blindness, with some attempt to localise the relative lesions. In the July number M. J. Delbœuf, pursuing the subject of "*La Matière brute et la Matière vivante*," attacks the origin of life and death! M. Victor Brochard considers the logical bearing of Belief, and M. Charles Secrétan follows on with an essay, half-hopeful and half-pessimistic, upon the revival of Thomist philosophy on the Continent and the general outlook for the next generation, set midway between Catholicism and Materialism: upon which again follows, oddly, a criticism of the third volume of Herbert Spencer's *Principles of Sociology*. In August M. Tarde was again active on the subject of the recent studies of cotemporary Socialism, those, namely, of Paul Janet, Emile de Laveleye, and Masseron. M. Ribot contributes a very long study of the "*bases affectives de la personnalité*," and there is a short notice of the French translation of Mill's *Utilitarianism*. September produced little of note, except a further instalment of M. Delbœuf's treatise on *Living Matter* and a notice of L. Fischer's book on *Hypnotism*. In October M. Delbœuf closed this series of papers, and M. Ribot went on with "*Bases Intellectuelles de la Personnalité*:" and two treatises were begun, one by M. Perez, on "*Theories of Education*," and the other by M. G. Pouchet, on the biology of Aristotle, both of which were continued duly in the following month, when M. Tarde contributed a very readable article entitled "*What is a Society?*" In November there came also a cloud of notices and reviews, including one of Stricker's "*Philosophie des Rechts*" and another of Kussmaul's book on diseases of speech, besides others on Bernheim's *Treatise on Suggestion* in hypnotic and waking states, De Varigny's *Researches on the electric excitability of the cerebral convolutions*, A. Bain's *Practical Essays*, the "*Journal of Mental Science*," and the *Proceedings of the Society for Psychical Research*.

PART IV.—NOTES AND NEWS.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Quarterly Meeting of the Medico-Psychological Association was held at Bethlem Hospital on Friday, 13th February, 1885, Dr. Rayner, President, in the chair. There were also present: Drs. J. Adam, S. H. Agar, R. Baker, D. Bower, C. E. Brunton, D. Brodie, C. Clapham, P. E. Campbell, W. C. Daniel, W. Eager, B. B. Fox, R. Jones, H. Major, W. J. Mickle, J. H. Paul, H. Rayner, R. S. Phillips, W. S. Roots, G. H. Savage, W. H. O. Sankey, H. R. Sankey, J. B. Spence, H. Sutherland, A. H. Stocker, H. Stilwell, D. Hack Tuke, C. M. Tuke, E. S. Willett, L. A. Weatherly, T. O. Wood, Wm. E. R. Wood, &c., &c.

The following gentlemen were elected members of the Association, viz.: C. T. Street, M.R.C.S. and L.R.C.P., Ass. Med. Off. County Asylum, Prestwich; H. T. Sells, M.R.C.S. and L.R.C.P., Ass. Med. Off. County Asylum, Prestwich; J. L. Leslie, M.B. and C.M. Aberd., Senr. Ass. Med. Off. Bethnall House, Cambridge Road, E.

Dr. SAVAGE submitted two pathological specimens, and said :—I have, as usual, got some specimens from the pathological side to contribute to this afternoon's session. The first is taken from the body of one of the chronic cases in Bethlem, and is a ruptured right auricle. The patient had been in Bethlem nearly half a century, and was about 90 years of age. He had become more and more weak-minded, and during the past few years had been too weak to be trusted to go about by himself, as he had been for years before. He caught cold, and the result was an attack of bronchitis, which in itself was not severe. He, however, one morning, as he attempted to get out of bed, fell down dead; and on post-mortem we found a large rent in the right auricle of more than two inches in length. In the pericardium there was but one clot of no great size; so that, in fact, it looked as if the heart had ruptured in contracting and never filled again, and no further flow of blood occurred. As might be expected, the arteries all over the body were very atheromatous; but beyond this, and general cortical wasting of brain, nothing noteworthy was found. In the second case, I exhibit a specimen of apoplexy of the cerebellum. This is sufficiently rare to make its record necessary, though I fear its interest is general rather than psychological. The patient, also one of the few incurables kept at Bethlem, had for over a year been developing heart trouble, and her breathing became difficult, especially at night; so that she would go to bed, sleep well for several hours, and then wake in extreme anxiety and dread. There was no doubt about the state she was in. She was seen both by myself and Dr. Wood in her paroxysms, and every remedy was tried to relieve her. At one time stimulants did good, but later nothing had any effect. She was seized three days before death with an unusually severe attack, which never subsided. Œdema of the lung followed, and the patient remained in a very wretched state, gasping for breath, till within 12 hours of death, when she suddenly tried to get up, fell back, and became unconscious. She never recovered consciousness, and died. After death we found old pleuritic adhesions over the right lung, the root of right lung tightly matted together, the arch of the aorta dilated and atheromatous; no bulging in any spot. The rest of the body was fairly healthy, but there was an apoplectic mass of the size of a large walnut occupying the lower surface of the median part of the right lobe of the cerebellum, and pressing into the fourth ventricle, but still contained within the membranes. The only symptom in life was the sudden springing out of bed, and a fall with a rotation as she fell. There was no skilled witness as to the direction of the fall, and unconsciousness at once following prevented further details. I have been much struck of late with the comparative frequency of hæmorrhage in the skull in cases dying of other diseases; cases in which the apoplexy is quite secondary, the apoplexy being but the local sign of a very general decay. General vascular degeneration is sufficiently common, but all its many vital symptoms are not sufficiently understood. In the first case, the old man might still have been living, with a fatty heart and the placid want of emotion common to the dement, had not bronchitis placed a bar to his circulation, thus causing the rupture on the right side; and in the second case, the apoplexy was but the final step in the downward process.

Dr. HACK TUKE exhibited some clothing material which he had obtained at Belfast, and which was intended to be used for destructive patients, it being very strong, a neat pattern, and washing well. It could be obtained by application to Messrs. Ewart and Co., Bedford Street, Belfast.

Dr. MICKLE asked Dr. Savage what quantity of blood was in the pericardium. In those cases of rupture of the heart the deaths were usually rapid, but not sudden, death seeming to occur from the pressure of the blood in the pericardium upon the heart mechanically stopping its action. Perhaps, in the case brought forward by Dr. Savage, the auricle being stated to have been enormously dilated, there might have been several ounces of blood effused. He (Dr. Mickle) had known one case in which there had been a very large amount.

Dr. SAVAGE said that the amount could not have been more than an ounce and a half. There was one small clot. It seemed that the absolute suddenness

had been sufficient to cause sudden death. He maintained that it was a charge of the auricle, because the clot was of the form of the auricle as if in contracting—not as much as could be possibly stuffed into the auricle, but as much as it would contain.

Dr. WEATHERLY mentioned two cases which he had met at inquests, in one of which the death took place in twenty minutes and in the other in a quarter of an hour. In both cases the pericardium was very distended, and in the first case there was a great deal of pain.

The PRESIDENT said that Dr. Hayes Newington was unavoidably prevented from attending on the present occasion to read his paper on "The Influence of Minor Uterine Troubles on Insanity." He therefore called upon—

Dr. HACK TUKE to read his paper on "The Insane in the United States." (See American Retrospect.)

The PRESIDENT, referring to what Dr. Tuke had heard in America that some British medical superintendents were in the habit of saying that restraint was never necessary, said that he had met a very large proportion of the British superintendents but had never heard one of them express that opinion, and he thought that most of the British medical superintendents had at sometime or other openly stated their view that they would use mechanical restraint whenever necessary; in fact, that they regarded the term "non-restraint" as being a misnomer, seeing that all confinement in an asylum was "restraint." With reference to the mode of admission in Massachusetts where it was necessary to have a Judge's order, but where an emergency certificate for one week was also provided, it would be interesting to know how often the emergency certificate was used, for they had heard that in other places where those certificates were in use there was more "urgency" than ordinary admissions. One of the cheaply built houses at Kankakee appeared to have been burnt down, and there was news, that afternoon, of the burning of an asylum in Philadelphia with a loss of several lives. As to the greater proportion of assistant medical officers he had himself touched upon that point some years ago in a letter to the "Lancet," and found the proportion similar to that stated by Dr. Tuke.

Dr. BRODIE said that his observations would be of a very limited character. On a former occasion he had visited all the then existing asylums in the States, but on this occasion his object was principally of a friendly character. He crossed the continent to San Francisco and was gratified to find that the new State had made a beginning in providing an institution for the training of imbeciles, and there they had adopted the same plan that Dr. Tuke had alluded to in connection with the insane asylums, viz.: of having separate buildings. They entered into possession of a place which had been used for white sulphur springs, and found three or four separate detached buildings there, and they thought that they would be an advantage to them. Another institution which he visited with extreme interest was the oldest institution in the States of that character, and was under the care of Dr. Brown, of Massachusetts. It was begun by Dr. Wilbur, late of Syracuse, and exhibited most satisfactory features in all its details, having one hundred and fifty acres of ground and eight buildings occupied by the children, who numbered 75. They were all paying patients, and it was entirely a private enterprise. The Massachusetts institution had altered somewhat in its relation to the State, for the notorious Ben Butler, when in power, had pounced down upon an insane asylum as a very useless thing, and prevented the usual annual appropriation from being made, compelling the asylum to charge the several counties of the State for the pupils they sent. At South Boston the work was being carried on in a very satisfactory way. A young physician had accepted the charge and was going on well. He heard of the existence and comparative prosperity of other institutions of that kind, but the three named were the only ones he visited. He saw the Middletown Asylum, mentioned by Dr. Tuke, and also visited the asylum at London (Ontario), in the gratifying report of which asylum he very heartily agreed, and he might supplement Dr. Tuke's remarks as to married assistant physicians by saying that he had seen three cottages presided over by married

attendants, the wives and children being present with them. It was surely a good thing when the attendants had the opportunity of being associated so thoroughly and permanently with their appointments. He had been very much interested in Dr. Tuke's paper.

Dr. BAKER said that he largely agreed with Dr. Tuke's paper. He should like to emphasize their sense of the very marked kindness with which they had been received by the American superintendents, and which was more than they could possibly have expected. Some of their medical friends drew up a programme for their visits and passed them on from one place to another, and by staying at the different asylums they had a much better opportunity of studying the inner life of the institutions than they would otherwise have had. As to the question of restraint, although, undoubtedly, it might be of service in individual cases, he doubted whether it was of much use generally. It was so exceedingly easy to introduce restraint, and so exceedingly difficult to discontinue it. He visited one asylum purposely on a Sunday, and counted twenty-six patients in restraint, not one of whom he should have thought of putting into restraint. On asking the medical officer the reason of this, he was told that not nearly so many patients would have been in restraint had they not been very short of attendants on Sundays, and therefore it saved trouble. At another asylum which he visited he asked how it was such-and-such a patient was restrained, and the sub-governor said that when he went round in the morning the patient was not in restraint; whereupon he (Dr. Baker) rejoined: "Surely you do not allow the attendants to place people in restraint?" "Oh! no!" was the reply, "of course not! They are always bound to report it in the evening when they do so." He really thought they ought to be exceedingly careful in using restraint. There was a very curious circumstance to be noted. In America there seemed to be a very grave distrust of asylums by the general public, which was shown by the power which the public had gained of being admitted to go over them. Seeing so many people about he asked the reason, and was told that the asylums were practically thrown open; they had had two or three thousand visitors in that year, twenty editors in one day, and so forth. Well, he thought that was extraordinary; and that feeling of distrust was showing itself in another way. People of the middle class were not generally liking to send their patients to the larger asylums, so small private asylums were springing up, and while in England there was an outcry against private asylums all round, in America they were being started. As to patients in an excited condition not getting so much open air as they would here, that was owing to the mistaken way in which asylums were constructed. Instead of one or two stories there were four or five, and the most noisy patients were, strange to say, placed at the top of the house. As a rule they certainly had good means of ventilation, and so the authorities did not care so much to get the patients out as would be done were these patients kept as in England on lower stories.

Dr. SAVAGE said that he had not been to America, but he had been to Gheel, the city of the simple, and the members might perhaps like to hear his remarks on what he had seen. In that district there were 1,700 chronic lunatics and a relatively small number of acute lunatics scattered nearly all over the country. There was a central establishment containing sixty patients, and he did not wonder at some visitors giving an evil report, for the central establishment, looking well from without, was within certainly not to be compared with even the worst of the English asylums; he meant for the very bareness of things. The whole thing was rough and plain, but then the patients had been used to very plain houses and did not seem to feel it. The baths were small and inconvenient. A few of the dormitories for quiet patients were excellent. The smells were dreadful—continental. Patients were first brought into the central establishment, then, if not troublesome, they were sent miles away into cottages. Sometimes they were hobbled. It seemed to him that extraordinary freedom was given. Going round, he would ask "Where is So-and-so?" and the answer would be "Well, sir, he was rather bad-tempered and he has gone

out." When a man had an attack of excitement they let him go out. Some others were fishing all day long. There was no doubt about the freedom, and the fact that patients could be managed as they were managed, being chronic cases, was interesting. Going about the streets his chief companion was a young Swiss, who had spent a small fortune as a "moral lunatic," as the doctor said, and who showed him the seamy side of Gheel. This Swiss said that he had heard both sides and neither view was true. He had lived there as a patient, going about and teaching German, and he also went out bird-coursing and entering into the other occupations of the place, and the only fault he could point to was the liability of the peasants getting too much work out of the imbecile patients. He said he was quite sure that there were a lot of quiet dements who were set to do mechanical work from early morning till late at night, the peasants setting them on the job and leaving them there, but undoubtedly the peasants fared better themselves. Every patient had from fifteen to eighteen-pence a day. The living there was cheap. A congress of medical men was being talked of in connection with the international assembly which was to meet at Antwerp this year, and invitations would probably be sent to members of that Association to go and visit Gheel at the same time. It was, of course, worth seeing. He had no remark to make on Dr. Tuke's paper except that he had been struck by the fact that the Americans paid most of their officers better than in England, but then there were no pensions.

Dr. HACK TUKE remarked that the medical superintendents were not so well paid. He mentioned the case of a distinguished superintendent who had only £500. In one instance a superintendent received £400 and the assistant £200 per annum.

Dr. SAVAGE said that every year it became more apparent that until insanity was treated more like other diseases, its treatment would not make the progress which it should. At a hospital considerable time was devoted to going round and talking about things with students and clinical assistants, but a medical superintendent in a lunatic asylum might think himself fortunate if he had about 250 or 300 cases to deal with all by himself. They were obliged to generalize without having the opportunities for discovery from which generalization ought to be made.

Dr. TUKE, in reply, said that as regards the President's remarks in reference to "non-restraint," it was constantly alleged and generally understood that the "non-restraint" system was accepted by English alienists and superintendents. The question depended, it would seem, upon the acceptance of the term "non-restraint." If it meant that it was not to be used except in surgical cases, and yet was really used in other cases, then he did not wonder at the Americans being surprised when they visited our asylums and observed even the few instances of restraint which might be seen. He was not objecting to this; he only wished for consistency of doctrine and practice. Then as to placing the more excitable cases on the upper stories. Surely it was a constant temptation not to let them go out when they ought to do so. They had all seen very serious struggles in bringing such patients downstairs, and it was sure to end in the patients not going out as often as they should. Certainly there was generally good ventilation at the end of these corridors by which the patients could get fresh air, but that was not exercise out of doors. As to salaries, it was to him curious to find an experienced medical superintendent getting only between £500 and £600 a year, while the assistants and the ordinary attendants were better paid in proportion, and certainly better than in England. As to the furnishing of the wards for excitable patients, he must say there was no asylum which he had visited in America where such wards presented the same amount of furnishing and decoration as they did at Bethlem. The other wards in American asylums were often exceedingly well furnished and most cheerful and pleasant. At the asylum, of Concord (New Hampshire), they had capital arrangements for friends visiting the sick. It was so arranged that there was a room nicely furnished adjoining the sick-room, and the friends frequently came and stayed for a week or two. This arrangement was very much

liked by the patients' friends, and it proved to them also the confidence which the authorities felt in the treatment patients were receiving in the asylum. He had not had time to refer to asylums for the criminal insane, but he might say that it was highly desirable there should be more of them in the United States. That at Auburn, New York, was the only one in existence.

Correspondence.

THE ABOLITION OF PRIVATE ASYLUMS.

To the Editors of the "JOURNAL OF MENTAL SCIENCE."

GENTLEMEN,—I conjecture that most of the members of our Society have seen, or at least have heard of an article which Dr. Bucknill has contributed to the February number of the "Nineteenth Century" on the "Abolition of Proprietary Madhouses." Very remarkable as that article is in title, conception, argument, conclusions, vehemence and picturesqueness of its periods, and above all in the intrepidity with which the writer has cut himself adrift from the well-weighed opinions of himself and others, and from many of the traditions of our Association, yet probably had Dr. Bucknill, as on a former occasion, withheld from it the prop of his name, it would have been allowed to pass, not perhaps without a shade of regret on our parts, that private asylums have yet again been requisitioned to supply the requirements of both readers and writers.

Before going into the issue between ourselves and Dr. Bucknill, I must advert to a matter in which the whole of the Association is interested. I refer not only to the title of the article, "Proprietary Madhouses," but to the unjustifiable use by him of such words as "keepers," "imprisonment," "captives," &c. It has been the object of all connected with the treatment of insanity to draw away even in nomenclature from the dreadful state of things that existed years ago. So fully has this tendency been recognised that an old rule, enacted in 1855, has been allowed to lapse, probably from its being considered to be supererogatory. Rule 17 ran—"That by the members of this Association such terms as *lunatic* and *lunatic asylums* be as far as possible disused, and that except for official and legal purposes the terms *insane persons* and *asylums* be substituted, and that generally all terms having an opprobrious origin or application in connection with the insane be disused and discouraged."

If even these terms were deemed undesirable, how much more so are those made use of by Dr. Bucknill. I feel sure that this relapse on his part will not meet with the approval of any one of us, and that this will be still more the case on account of its having occurred in a lay publication.

That Dr. Bucknill has in times gone by thought better and spoken in a more brotherly manner of the proprietors of private asylums, will be made manifest by a reference to his presidential address in the year 1860 ("J. M. S.," Vol. vii). In this will be found not only a general exhortation to unity, but a positive deprecation of "contention," "jealousy," and "the assumption of difference of feeling on personal grounds."

However, this is a thing of the past, and a protest must be entered if only to save us from the reproach of acquiescing by silence in the truth of his statements.

Delenda est Carthago!—In such words Dr. Bucknill proclaims that the total abolition of private asylums, without compensation, without pity, is the only thing that will satisfy him. This, the sole aim and end of his article, he supports with a variety of reasons—scientific, social, and professional. Among other grounds for this destruction are the following:—The existence of a pecuniary interest to do that which is wrong (this leading to the admission of people that should not be admitted; the neglect to attempt any curative treatment; the detention of people after they ought to be set at liberty); the

absence of any particular need for such institutions ; and the ease with which they could be replaced. Besides these, there are several little and sly thrusts which I will deal with afterwards. Though these views of Dr. Bucknill's now see light for the first time in lay pages, they are by no means recent so far as he is concerned. In 1879 (it is important to mark the date) he published a series of anonymous papers in the journal of the British Medical Association, in which he insisted on the unworthiness of private asylums and all connected with them with an amount of fire at least equal to that which he now displays. I say that it is important to notice this date of 1879, for I wish the reader to compare with the foregoing what had been said by Dr. Bucknill only two short years antecedently, before the Select Committee of the House of Commons which sat on the question of the liberty of the subject.

The following are some of the answers which Dr. Bucknill made in reply to various questions asked of him :—

(Q. 1,860.) : “ I do not wish to find fault with asylums ; I hope that I have not let anything fall to imply censure. Our public asylums are unrivalled, and they are what the nation and the profession may equally be proud of. With regard to the private asylums, you will find no such private asylums anywhere else in the world, and the improvement which has taken place in them in the last thirty years is equal to the improvement in any other class of institution with which I am acquainted. Still one wants to get the bad ones up to the mark of the best.”

(Q. 1,908.) : “ I think there is ample room for the existence of both classes of institutions. I cannot express too high an opinion of the hospitals for the insane. I think that side by side with them the private asylums may contrive to exist very well, performing a somewhat separate function.”

(Q. 1,909.) : “ In any case do you think it desirable that keepers of private asylums should have a direct pecuniary interest in the patients confined in them ? ”—“ If you had to begin *de novo*, I should say it would be a bad principle to adopt, but the thing exists, and there is a large interest in it, and it would be very difficult, and I think undesirable, to abolish it. The right policy, I think, is to try and improve these places as much as possible.”

(Q. 1,910.) : “ Would it not be desirable to get rid of them by degrees ? ”—“ I should be sorry to see them got rid of.”

(Q. 1,911.) : “ May I ask why ? ”—“ Because the best of them serve a very useful purpose. I do not know that the hospitals for the insane would quite replace them ; certainly, they would be very far from replacing some of the private asylums with which I am well acquainted.”

“ *Tutanda est Carthago !* ” said Dr. Bucknill in 1877. Private asylums are *not* to be destroyed, even in a gradual fashion. They can *not* be replaced, and if they were abolished, Dr. Bucknill would be very sorry. There is great need for them, and it would be undesirable and very difficult to get rid of them. And, lest by any chance the directness of this evidence should be prejudiced by what he might have said, Dr. Bucknill hopes that he will not be considered to censure !

The reason for carefully noting the dates of these expressions of opinion will now be quite apparent. The case really stands thus :—In 1877, Dr. Bucknill, relying on his experience of thirty-four years' official career, utters serious and deliberate words, on which two years later, when he has taken up private practice, he publicly proceeds to turn his back.

I have no wish, nor indeed right, to deny Dr. Bucknill the privilege of changing his mind. But I have a right and every intention to deny that it is lawful for him to give the impress of long experience to what is but a mushroom opinion. In the cause of the improvement of private asylums he is a Nestor ; in the cause of their destruction he is a neophyte.

Nor is his tergiversation confined to the point now under consideration. Evidences of it are strewn through his later writings. To take a very serious subject, which is raised in the February article—the placing of acute and chronic cases in that sphere which is most likely to lead to their welfare.

Dr. Bucknill now says that he hopes to see the erection of small establishments where acute cases can be readily treated in emergency, pending speedy recovery or removal elsewhere. He also recommends the erection of three large asylums for the accommodation of the 600 more or less chronic chancery patients that are now scattered in comparatively small quantities in private asylums.

In "Psychological Medicine" (Bucknill and Tuke, 4th Edition, 1879) there occurs the following passage from the pen of Dr. Bucknill:—"The asylum should contain a considerable number of patients. Some small private asylums with few inmates are well adapted for the continued residence of chronic lunatics needing more care at less cost than can be provided in private dwellings. Such asylums are excellent for the care and detention of chronic lunatics who are not fit for the enjoyment of domestic life, but they do not and cannot offer the means and appliances for the curative treatment of recent cases. For these an asylum containing at least thirty or forty patients should be chosen, and one containing four or five times that number should be preferred. A certain minimum number of fellow-patients is needful to establish that system of method and discipline which forms the great part of the curative influence of asylum treatment. The great importance of this influence upon the insane mind we have always insisted upon. Orderly conduct and obedience to conventional rule, though it be but that of an asylum, is the first step towards reasonable processes of thought and healthy states of emotion, and the lunatic placed in an asylum very constantly falls into the order and the rule of the house, as a boy, rude and unmanageable at home, falls into the order and rule of a great school."

In the preface to a little book, "The Care of the Insane," which came from Dr. Bucknill's pen in 1880, I read: "But after all a congregation even of pauper lunatics is a great, though doubtless an unavoidable evil, while a system which compasses the herding together of lunatics of large fortune, or even of competent means, for any purpose but the important one of public safety, is but a mouldy method of routine and prejudice. For opulent patients, certainly the smaller the asylum is the less the objection to it."

What is to be made of all this? Here we have as touching acute cases, a definite and scientific statement, founded on logical reasoning, which must commend itself to all, and which has acquired fresh confirmation from each of the several editions containing it, utterly hashed by a subsequent opinion. So too with regard to chronic patients. The massing of patients (it is "congregation" in the case of paupers and "herding" for the rich) is strongly condemned. Yet in a short space of time Dr. Bucknill proposes to build asylums to contain an average of 200 chronic patients, which is a very large number indeed for paying patients.

As I have said before, one may have the privilege of changing his opinion within certain limits, on social or administrative points, but no one can be allowed to play fast and loose with scientific teaching without incurring the penalty of sensibly diminishing his authority, which, in the case of Dr. Bucknill, had at one time no superiors and but few equals. It is also to be regretted that science has fallen a victim, not to science, but to social crotchets.

It will be convenient here to add an extract from Lord Shaftesbury's evidence given before the Select Committee of 1877. I think that it will be seen to put a complexion on that portion already quoted by Dr. Bucknill, very different to that which he assumes.

His lordship said (Q 11,357.): "And indeed the state of things before 1859 was very bad indeed, but at present, from a variety of causes, the licensed houses are in a far better condition in every sense of the word; more is expended on them by the proprietors, and I must do them the justice to say that the change is very great, and so far as the evidence I gave in 1859 is concerned, I should not give it now. I can speak in high terms of many licensed houses and proprietors, but I will also add that if you relax your vigilance ever so little, whether it be of licensed houses or of hospitals, or of county asylums, the whole thing will speedily go back to its former level."

There are four principal items of offence laid to the charge of private asylum proprietors that require to be met, these being—the influence of pecuniary interest; the admission of people who ought not to be admitted; the neglect of curative treatment; the detention of patients after they ought to be set at liberty.

To begin with *pecuniary interest*. It is astonishing how easy it is, when anything harsh or bitter has to be said, to assume that the readiest means of offence is the truest. It is so in this matter, but several fallacies are lying just underneath the surface. First, is it necessary to assume that a money interest exercises the chief or most powerful effect on a man's conduct? Are not passion, spite, envy, hatred, malice and all uncharitableness, on the one hand, and ambition, pride and that form of pride which impels one to wish to stand well with one's fellows on the other, oftentimes quite as strong as money? Secondly, is it right to assume that, when a man's interest may lie in a vicious direction, he will of necessity follow it? If this be the case, who among us is safe? The judge, the trustee, the banker, the solicitor, all must have opportunities of temporarily increasing their possessions by wrong-doing. But are they necessarily suspected on this account? It is true that they are hedged round with certain checks, not the least of which is the terrible consequence of discovery; but this is precisely the case with us. Thirdly, to take still lower ground, let us even admit that pecuniary interest is all-powerful. Is it then necessary or practical to assume that the most money can be made by ill-doing? We have had a free present made us of "trade" principles. Are we to throw the most prudent of these away, and sacrifice permanent success to temporary gain? Let the reader put the question to himself whether he can conceive any circumstances in his own calling which will induce him to risk that calling at any such price as he may be likely to obtain for his evil actions. I do not say, and I do not wish to appear to say, that such considerations form any safeguard in this or any other profession. I do not maintain that pecuniary interest does not occasionally warp a man, but it will be apparent from these reflections that it is fallacious to say that it *must* do so in any or every case, or even in the majority of cases.

On the other hand, if it is possible to show, as I hope to do in no uncertain way, that pecuniary interest does not exert a bad influence, then surely it will be of the greatest service in ensuring a maximum of proper attention and kindness to our patients.

Thus far I have, in speaking of pecuniary interest, been acting on the defensive. Looking to the nature of the attack made on us, it should not be considered to be improper if I seek to improve our position by carrying the war into the camp of a hostile witness. It will be readily seen that our interests may be opposed to those of others than the patient. In the report of the Select Committee of 1877 (Q. 9,428) there will be found a quotation from a letter, in the course of which the following passage occurs:—"I have the written opinion of Drs. Bucknill, —, —, and —, that my client will suffer harm if he be detained in retreat, and they recommend his being placed either as a sole private patient with a medical man (such a man as Dr. Bucknill for instance, if he would undertake the duty) or in his own house with medical supervision." Now I do not for a moment wish it to be understood that I think that Dr. Bucknill gave such an opinion to obtain the charge of the patient. I will even go so far as to say from my own knowledge that he did not. But the pecuniary advantage that would result to him from such a course is obvious, and his doctrine of the consequence of pecuniary interest will apply to himself as rigorously as he has applied it to us. unless he could clearly show that at no time had he either had this or any other case under his remunerated supervision in his own or other private house. If he has been, or is now taking such charge, the logical application of the doctrine would run something like this—if it pays to supervise one patient, it will pay better to supervise several, and therefore several must be found. The more patients admitted into, or detained in asylums, the fewer will there be to go into private supervision; therefore pecuniary in-

terest leads to patients being kept out of asylums, or dug out if they are already there. Pecuniary interest being still dominant, what is the best way of effecting this? *Delenda est Carthago!* What would Dr. Bucknill say of us, if we went out of our way to gratuitously insult him in such fashion?

Admission of people who ought not to be admitted.—I must confess to finding some difficulty in framing an answer to this. If the charge had been made that absolutely sane people were taken in, then nothing would have been easier than to bring overwhelming evidence to prove that such a course was hardly possible now-a-days, and would be too risky for anyone to try it with any hope of success. I do not think that private asylum proprietors are yet in a condition in which they would want to increase their business in this manner. Still it is possible that such a person might be received, not in fraud however. It is shown in the report quoted before, that mistakes do occur, not in the case of the rich so much as with the poor. Dr Bucknill (Q. 1,892) says: "I have known cases at the Devon County Asylum sent in who were not insane; several cases." Dr. Lockhart Robertson being asked (Q. 1,215): "You would put it that at long intervals and in rare cases mistakes as to people's sanity would necessarily occur?" said "Yes." Mr. Commissioner Wilkes being asked (Q. 804): "You stated just now that all persons to your knowledge who were received into asylums were actually lunatics?" said "Yes; it is very rare that any question as to the lunacy of the patient occurs." Many others give the same evidence. Therefore we may take it, on the authority of those who know well what they are saying, that admission of actually sane people is extremely rare. Beyond this we see that when a mistake does occur it is at the hands of the certifying doctors, and generally takes place in cases where there cannot possibly be any pecuniary interest. Why then should persons go out of the way to assume that the pecuniary interest of the proprietor is responsible for the misfortune?

The question of admission turns far more frequently on the matter of the sufficiency of the insanity in a person who is undoubtedly insane. Here again, if there is any harm done, it rests primarily on the certifying doctors. Of course there are insane people as to whose fitness for detention there can be no manner of doubt. On the other hand, there are insane persons who can obviously be treated better outside than within an asylum. But when we leave these two extremes and travel inwards, there must come a point when doubt arises, and unfortunately experience shows that these doubtful cases are those that may develop dangerous tendencies which are for the time obscured by the presence of intellectual power. Take the following instances. The unfortunate gentleman who some years ago shot at the Master of the Rolls had been going about under the belief that his legal grievance was not properly taken notice of. No one thought that his ideas were sufficiently absurd on the face of them as to warrant his being deprived of liberty. But when he had committed the offence it was discovered that he was insane, and a subsequent murderous assault on the Medical Superintendent of Broadmoor clearly proved him to be a most dangerous victim of a grievance. Again, it will be remembered that the man Goldstone killed five of his children last year. This man was ultimately proved to be clearly insane, and his fellow-workmen had noticed that he had been peculiar for some little time. Still, he was able to do his work and keep his family. Who dared to interfere with these men until the deeds were done? Can doctors be blamed for doing their best to anticipate such events? If they are simply to wait until the questioned insanity reveals itself by deeds, the familiar crossing-sweeper could sign a certificate just as well as the medical man. Dr. Maudsley said (Q. 3,752): "It is just a matter of opinion. There will be sometimes difference of opinion whether a case is a proper one to be sent or not, but medical men may differ perfectly honestly on a matter of that kind." Then if medical men acting on their belief send us a patient, are we to be blamed for accepting their view of the case, at all events till sufficient time has elapsed to show whether their opinion is a sound one? Are we, with but little knowledge of the facts, to take the

responsibility of reversing, possibly to the public harm, two opinions founded on facts? The law evidently does not take this view, in that it authorises us, in case of action, to plead the certificates, thus throwing the responsibility on the certifiers. All we can do is to watch the case, and if necessary get rid of it at once, which is the course that most prudent men would take.

Neglect of Curative Treatment.—It is freely alleged that private asylum proprietors do not attempt to set their patients straight—that they prefer to make sure of the bird in the hand, fearing they may not find others in the bush. I need hardly point out the absurdity from the “trade” point of view of such a course. We will see what figures have to say—whether we do not only make the attempt, but also whether we are not as successful as our brethren, allowance being made for various differences in opportunity, which I will refer to presently. Taking the average for the last ten years, and excluding all idiot establishments, the following are the recovery rates, roughly:—County asylums, 40 per cent.; hospitals, 47 per cent.; private asylums, 33·5 per cent. It will be allowed that, if we do not make the attempt, a considerable number of our patients are supremely fortunate in getting well without help. It will be seen, however, that private asylums are behind both classes of institutions. This has given rise to disparagement in quarters that might have been better informed.

There are several reasons for our not being able to vie with others. Chief of these is the fact that while in a pauper asylum there will be found a fair representation of all forms of insanity, mild or severe, chronic or recent, in private asylums this is not the case. Many of the upper classes can and do retain the services of independent specialists and get well without leaving home, or are sent away to medical men's houses. We, therefore, can say that we have not the comprehensive range of other asylums, and that what we do get are not infrequently the residue of unsuccessful treatment elsewhere. Again, on no other point in connection with insanity is skilled opinion so united as on that of the efficacy of early treatment. In fact, a large collection of statistics shows that if cases are brought to asylums within three months of the onset of disease a proportion, variously estimated from 60 to 75 per cent., recover, while if asylum treatment is delayed for twelve months from 5 to 15 per cent. only have this good fortune. Now it is evident that if a poor man or woman becomes insane he or she must be taken off to the asylum at once, if only because there is no possible chance of home treatment being carried on. But in the case of the wealthy it is well known that an asylum is generally the last thing thought of. Then, if cases improve, the friends are very apt to remove a wealthy patient to complete the recovery at home, whereas with the poorer people administrative reasons insure their being retained till recovery has been well established. Thus both at the commencement and at the end are we deprived of an appreciable chance of swelling our totals of cure. Our material also is more unpromising. In the Commissioners' reports from year to year will be found a series of tables (XXII.-III.) that give the assigned causes of insanity, and a contrast is made between the private and pauper patients. These tables so nearly resemble one another each year that their substantial value may be assumed. In these it is well shown that the more unfavourable of the *moral* causes preponderate in the rich, while those connected with *physical* derangement, more or less easy of amelioration, are found in the poor. Mental overwork and worry (independent of family affliction or adverse circumstances) are instances of the former, while the latter may be represented by privation and starvation. Occupation, healthy in extent and nature, is denied to the rich in a proportion that does not obtain with the poor. The latter have manual work and trades that they can easily fall back on, those parts of their system which they have been in the habit of using in seeking their living being those that are free of the disabling disease. With the rich, unfortunately, the reverse happens. The brain, which has been their working instrument, is either incapable of exercise or is in a condition that makes it unwise to subject it to work of any kind. In occupation I do not include

amusement; this is probably provided quite as liberally in private as in public asylums. Taking all these considerations together, I think that we may claim credit for not being more behind other institutions. At least it is absolutely false to say that a proper attempt to cure is not made.

In connection with the foregoing it is a curious fact that while one in ten of the patients discharged from private asylums returns at some future date, one in seven and one in seven and a half return to hospitals for the insane and county asylums respectively. These figures are calculated on the last five years, and from them those relating to idiot establishments are excluded.

Improper detention of patients after they ought to be set at liberty.—This is one of those shadowy and impalpable accusations that it is almost impossible to meet by mere argument and assertion. It was shown everywhere in the report of the Select Committee that the fitness for discharge of a patient must always be a matter of opinion.

I can place the whole matter of the detention of patients in a mathematical light that cannot be gainsaid. If patients are improperly detained it will follow that those who so detain them must have, after a time, an accumulation of patients in excess of the general ratio, which would soon proclaim itself. But what is the case? Private asylums are very much where they were ten years ago in point of numbers, though the admissions into them are relatively more numerous than those into other classes of institutions.

Now it is my object to show not only that patients are detained no longer in private asylums than in other places proportionally, but that they even are removed from the former much more rapidly than they are from the latter. All the following figures are averages for the last five years, and are taken from the reports of the Commissioners in Lunacy. The average numbers resident in the various institutions on January 1st of each year are as follows:—

County Asylums.	Hospitals.*	Private Asylums.
41,414	1,657	4,224
The average removals in all ways—by death, by recovery, or by discharge of those who are not recovered—are:—		
County Asylums.	Hospitals.*	Private Asylums.
10,720	449	1,710

Let us suppose that all admission is stopped, in each class of asylum, and let the removals go on; then it would take 3·69 years to empty county asylums, 3·86 years for hospitals, 2·47 years for private asylums, or, in other words, the average time of residence in a private asylum is about two-thirds of that in either a county asylum or hospital.

Now, if mathematical facts have any value at all, it must be admitted that, so far from patients being unnecessarily detained in private asylums, they are sent away or removed considerably faster than from other places. What becomes then of the charge of detention? It is true that it is still left for a critic to say that it is the poorer patients who are the happy ones to leave, while the rich are left to languish. But the margin is too great, and my own experience is directly antagonistic, for I find that as a rule the greater the riches of a patient the greater is the tendency for the friends to remove him for trial under other circumstances, if reasonable prospect of recovery does not show itself.

I will quote a passage from the evidence of Dr. Crichton Browne. Being asked (Q. 1,269): "Is it your opinion that patients are kept longer in private asylums than they ought to be?" he says: "I cannot say that I have myself come across a case officially." (Q. 1,270): "You do not think that takes place more among those who pay most?"—"No; I am bound to say that I have had

* In the hospital figures I have omitted those relating to Bethlem. Patients are chiefly admitted into this institution for one year only, and must leave at the end of that time, whether well or not. Therefore it would manifestly be deceiving to admit them into a calculation which deals with the duration of residence of patients.

the medical officers call my attention several times to patients whom they thought might be discharged, when I have had to express a different opinion, and to say that a little prolongation of treatment might, in my opinion, be advantageous."

Dr. Bucknill has quoted a passage from a pamphlet by Dr. Wood. When I read it on its publication I felt that it might well have been omitted, not because I absolutely disagreed with it, but because I was sure that sooner or later it would be laid hold of in a sense that was quite foreign to its spirit. Probably what Dr. Wood intended to be conveyed would be ruled very much by the same conviction as that of Dr. Bucknill when he told the Committee (Q. 1,893): "Very few persons leave asylums who are perfectly strong." However this may be, it is evident that Dr. Bucknill must have been a party, unwilling, no doubt, to just the same offence, in old times, for we find from Q. 1,933 *et. seq.* that it was the custom in the Devon Asylum to discharge recoveries once a month, on Committee days. Did all the many hundred patients who recovered under his administration do so on these particular twelve days in the year? If not, why were they detained after recovery? To help to establishment of that recovery, or to suit the convenience of the Committee?

Before I leave this subject I must give yet another quotation from Dr. Bucknill. Asked (Q. 1,828): "What do you think is the usual motive for keeping patients too long?" he said: "It is very hard to impute motives. I should not like to do so."

I venture to think that I have supplied an amount of information on these points that will cause the reader to pause before he accepts the conclusions of Dr. Bucknill, which are in themselves only serious as being to a certain extent shared by that portion of the public which will accept any sensational statements concerning what it is profoundly ignorant of.

There are one or two other matters in Dr. Bucknill's paper that I should have been glad to have left alone as rather below the tone in which a grave subject should be discussed. But as these are brought in for a definite and destructive purpose, and are themselves evidence of the spirit in which the whole article is conceived, I can hardly afford to do so.

Dr. Bucknill assumes that private asylum proprietors are "tradesmen." He cuts us off from the other members of the profession, so that they may be absolved from any duty to their unfortunate brethren who are in stress from his and similar attacks. The public must know, too, that we are not entitled to any of the consideration that the medical profession expects at its hands. He makes broad his phylacteries, and, by implication, thanks his God that he is not as the poor proprietors are. But look! *Horresco referens!* Dr. Bucknill will find his name, certainly in the best of company, among the "trades" in Kelly's Directory. He starts with an extraordinary statement—that ordinary medical men's receipts are either honoraria or payment for work done, and are not *profits*. The only conclusion that can be drawn from this is that if anything but brains and work are provided in return for fees, then these fees are profits; also, from the context, he appears to assume that profits belong to a trade only, and not to a profession. If that is the case, which of the outside medical profession does not provide himself, for business purposes and the use or convenience of his patients, with either instruments, medicine, carriages, door-plates, houses at more or less expensive rates and in suitable position? Again, supposing that a person living one hundred miles from London is uneasy in his mind, and that it is considered right by his friends that he should have the professional services of Dr. Bucknill. If this person can come to London and see Dr. Bucknill at his own house, he does so at a cost of one or possibly two guineas. But supposing that the patient cannot be brought up to town, and Dr. Bucknill has to go down. For this Dr. Bucknill is entitled to charge at the rate of two guineas for three miles, according to the scale of the College of Physicians

(which body, by the way, seems to have played the part of Balaam to his Balak). When he arrives he gives an opinion which is exactly equal in value to that which he would have given at his own house for two guineas. But he receives sixty-six. What are the extra sixty-four given for? The truth is that when a man receives money in return for anything, he may be said, in a sense, to be in trade. He is a tradesman, but what is there derogatory in that?

It will be news to the public that, as Dr. Bucknill implies, any disorder that does not interfere with the general peace or welfare of the institution is permitted in public asylums, because there is no pecuniary interest to repress it. It will be news also to the superintendent of the asylum that he does not vex his mind if a patient breaks any amount of furniture, glass, or crockery, or even sets fire to bedding or clothing. I fancy that, if this occurred often, his Committee would forcibly point out that it was to their interest that such proceedings should be repressed.

All this is anent the unwholesome handing down of a business from father to son or nephew. I should have thought, and probably others will think, that there is no particular harm in a future official being "in a manner born to it."

One of the many ingenious reasons for our disestablishment is that, rightly or wrongly, the public has a distrust of private asylums. This I know to be a far from correct idea. How is it that private asylums "contrive to exist very well side by side with the hospitals for the insane, performing a somewhat separate function?" Dr. Bucknill scouts the "white-washing" and the weak-kneed suggestions of the Select Committee. But who helped them to white-wash, and whose evidence rendered drastic recommendations unnecessary? And who is now responsible for disquieting the public mind?

Real harm does arise from this disquiet. From my own knowledge, which is a considerable one, of the feelings of the relatives of patients, I can say that many of the latter are brought, sometimes too late, whose coming has been delayed by the reckless assertions which are made. When they find out what the actual facts are, they blame themselves for taking these assertions for gospel, instead of looking into the matter themselves. The only cure for this state of things, the only way to minimise the harm done, is to attempt to enlighten the profound ignorance of the public in relation to all that concerns the treatment of insanity. If anyone desires to be so enlightened and thus render himself comparatively independent of the possibly biased opinion of a single man, let him eschew "popular" works and papers. Let him take the report of the Committee that I have so largely quoted. He will there find the ideas of most of those whose opinion is worth having, trammelled, it may be, by a sense of responsibility, but none the worse for that. He will find these oft-recurring accusations cross-examined, and I think he will find some evidence that even private asylum proprietors have a desire for, and some success in doing their duty. One thing I can say from the experience which my position gives me, and that is, that if private asylums are abolished, the country will have to reckon with a vast increase of treatment of insanity at home or in private residences; if in the former, all the benefit of asylum treatment will be lost; if in the latter, the patient will not only lose these, but he will be exposed in an enhanced degree to all the evils which are alleged to appertain to private asylums. The patients will be the losers: who will be the gainers? Those who have not devoted their lives to the work, and those who have to medically supervise the latter. If it is right, as there can be no shadow of a doubt it is, to hedge the insane round with all manner of protection by inspection and report, surely it is better, safer and more convenient that it should be done in those places where there are the most jealous eyes to watch.

I do not intend to say that *all single care*, as it is called, of patients is wrong. On the contrary, many cases, if carefully selected, do as well in a family as in an asylum. But when a great number are driven, as will be the case, to this form of treatment, not by process of selection, but by the undoubted dislike in many instances to any public institution, then I say great evil will arise. That

there is such a dislike is proved by the fact that notwithstanding all the benefits conferred by registered hospitals, so widely made known and patronized by Dr. Bucknill and others, these institutions as well as private asylums have not practically changed their respective numbers in the last fourteen or more years.

It will not be right to assume that the contrast, drawn by Dr. Bucknill between the payments made by the sane patient to a general practitioner, and those made on behalf of an "unwilling captive," applies only, as far as the latter is concerned, to private asylums. There are some public institutions which have an excess of income over expenditure that is really quite comfortable to look at. If to that is added the salary of the medical man, as it should be to make things equal, then we may take it that the "captive" has to pay pretty smartly in public as well as in other institutions. The truth is that the payments are entirely a matter for the friends, who are substituted in the contract for the incompetent patient. I think that as a rule these friends do not lose, when dealing with insanity, the national commercial instincts. They are very apt to see that they get a good deal for their money.

Dr. Bucknill has rightly said that it is impossible to discuss lunacy matters without reference to Lord Shaftesbury. I think that I can hardly do better than close this letter with this quotation from his lordship's utterances:—

(Q. 11,613): "I am decidedly against their being done away with by the prohibition of the law, and because, as I said before, I am certain that some licensed houses ought to exist. There are a great number of people who will prefer them for their relations. The treatment that you get in the licensed house, where it is well conducted, will always be more of the domestic character. I was saying that by the extension of the hospital system, that is of the public system, I believe that a great number of the inferior houses will be eliminated and got rid of, and the few that will survive would be very good." (Q. 11,614): "Are you of opinion that it would be prejudicial to advance in the treatment of mental disease to do away with licensed houses?"—"Most undoubtedly."

I am, your obedient servant,

Ticehurst, March, 1885.

H. HAYES NEWINGTON.

To the Editors of the "JOURNAL OF MENTAL SCIENCE."

GENTLEMEN,—In the January number of the "Journal of Mental Science" there is an able paper by Dr. S. Rutherford Macphail, entitled "Clinical Observations on the Blood of the Insane."

In it he makes the following statement (pages 488 and 489):—"I have been unable, in the literature to which I have had access, to find reference to any observations on the state of the blood in this disease" (General Paralysis).

Permit me to remark that on the 22nd of April, 1878, I read a paper "On the Histology of the Blood of the Insane" before the Royal Medical and Chirurgical Society, an abstract of which I enclose from their proceedings.

Dr. Lauder Lindsay had preceded me in a paper on the same subject, so that I can lay claim to no original merit in having prosecuted these researches.

It is somewhat gratifying to me to find that both observers, one of whom was before and the other after me, have arrived at the same conclusions as myself.

Dr. Macphail's paper is more elaborate and better in every respect than mine, but I am sure he will agree with me that, having published a paper twelve years ago on this interesting pathological question, I could not well allow his statement, ignoring Dr. Lindsay's paper and my own, to remain unanswered.

Trusting you may find space for this letter and abstract in an early number of the Journal,

I am, yours, &c.,

HENRY SUTHERLAND.

PROCEEDINGS OF THE ROYAL MEDICAL AND CHIRURGICAL
SOCIETY.

APRIL 22ND, 1873.

Charles J. B. Williams, M.D., F.R.S., President, in the chair.

The following communications were read :—

II. "On the Histology of the Blood of the Insane." By Henry Sutherland, M.D., Lecturer on Insanity at the Westminster Hospital. (Received March 11th, 1873.)

(Abstract.)

In this paper the results of the microscopical examination of the blood of 143 lunatics were described in detail.

All the patients who were made subjects for experiment were in fair bodily health, and their blood was examined after the same interval of time in all cases.

The inspections under the microscope were also made as nearly as possible at the same period after the blood was drawn, so that all fallacies in observation were reduced to a minimum.

It was remarked that any great augmentation of the number of white corpuscles usually indicated a low degree of vitality in the insane, and that the cerebral disorder had made some considerable progress; also that an absence of rouleaux-forming power in the red corpuscles coincided with a similarly depressed state of health.

These two conditions were followed by a speedily-fatal termination in a large proportion of the cases in which they were observed. These observations applied chiefly to cases of general paralysis of the insane in the male. In ten men suffering from this disease, whose blood was found to exhibit one or other or both abnormal conditions, five died within three months from the date their blood was examined. One of these men was in a moribund condition at the time the blood was drawn, but in the other four patients there were no symptoms which indicated such a rapidly fatal termination to their cases beyond the presence of these peculiarities in their blood. These remarks, however, do not apply to the same extent to this disease in women, the prolongation of life in female general paralytics being accounted for by the fact that the disease does not run so rapid a course in females as in males, and that in most asylums the females live longer than the males, because they are more comfortably provided for on the women's than on the men's side of the hospital.

Absence of rouleaux, together with an increase in the colourless corpuscles, appear to be conditions almost peculiar to general paralysis, and were observed in four out of 29 (male and female) cases, or in 14 per cent. These two appearances were found to co-exist in only four other cases out of the 143 examined, or in three per cent. of the whole number. Absence of rouleaux alone, and augmentation of the white globules alone, were found to exist in other less fatal forms of insanity, but not to the same extent as in general paralysis.

The conclusions drawn from the examination were as follows :—That in the insane generally a leucocythæmic condition frequently exists. That any great increase in the number of the white corpuscles at the expense of the red, and an absence of rouleaux from the blood of the insane, are conditions which generally indicate a very low degree of vitality. That in general paralysis, epileptic insanity, and masturbatic insanity, the blood is more deteriorated, and the vitality is more lowered in the male than in the female. That in mania, melancholia and dementia, the blood is more deteriorated and the vitality is more lowered in the female than in the male.

INSTRUCTION OF ATTENDANTS.

It is almost impossible to over-estimate the important duties attendants have to perform, and anything which tends to help them to do them effectively deserves praise and support. Such an object is surely a very fitting one for our Association to assist and encourage, and the thanks of its members are due to those who must certainly have spent no inconsiderable time and labour over the *Handbook for the Instruction of Attendants on the Insane*, prepared by a sub-Committee of the Medico-Psychological Association, appointed at a meeting in Glasgow on the 21st February, 1884. It is a very praiseworthy endeavour to inform and raise the tone of attendants upon the insane. Opinions will differ, we cannot doubt, as to whether some parts of the instructions are desirable. In the main we think they will be approved. We are not quite sure ourselves whether it is necessary or wise to attempt to convey instructions in physiology, &c., to ordinary attendants. Will they be the better equipped for their duties for being told that the brain consists of grey and white matter and cement substance? Or that "the grey skin of the brain may be compared to a great city, the head-quarters of the telegraph system, and the grey clusters scattered through the white substance of the brain are the suburbs," and so on. We hardly see what is to be gained by superficial knowledge of this kind. However, we may be mistaken; and our criticisms, or rather misgivings, do not apply to the practical directions given. We certainly hope that this Handbook will be in the hands of all our attendants. We have only to add that copies can be readily obtained through Dr. Campbell Clark, Bothwell, Glasgow. It is understood that this issue is experimental, and suggestions, therefore, will be gladly received, with the view of making the Handbook supply what is felt to be a real want in most of our asylums.

Obituary.

DR. W. A. F. BROWNE.

We regret to have to record the death of Dr. Browne, of Dumfries, on the 2nd of March, in his 80th year. Death appears to have been sudden at last. Happily, notwithstanding his advanced age, his mind remained clear.

He received his education at the High School, Stirling, and studied medicine at the Edinburgh University. He became an ardent disciple of George Combe, and occasionally lectured for him. In his work, "What Asylums were, are, and ought to be," he expressed his strong conviction of the truth of Phrenology and its extreme practical importance to the physician of the insane. That he and others should commit themselves to the doctrines of Gall, Spurzheim and Combe, not only in their general outline, but in their organological details, is one of the problems relating to systems once tenaciously held, but now discredited, which might be discussed with interest, but this is not the occasion to pursue the subject further. Dr. Browne will be remembered for the good work he effected, first as Superintendent of the Montrose Asylum and subsequently of the Dumfries Royal Institution. The latter was opened in 1839, Dr. Browne being the first superintendent. He held this post till 1857, when, in consequence of the revelations of the terrible condition of the insane in Scotland, a Lunacy Board was instituted, and Dr. Browne was appointed a Commissioner. It is true he looked with no friendly eye upon the visit of Miss Dix to Scotland and the agitation which followed, but the experience he obtained in his new office soon convinced him that there was but too much ground for the outcry which had been raised. The work done by him and his colleague, Sir James Cox (also a disciple of Combe), in their capacity of commissioners, was soon effective in improving the state of the insane in their various domiciles. At the age of 65 Dr. Browne had the great misfortune to lose his eyesight through a carriage accident, and with this of course ceased his duties as Lunacy Commissioner. His cheerful resignation to his lot for fifteen years was as admirable as the assiduity which characterised his course when in the enjoyment of full

health. Notwithstanding his blindness, he continued to take great interest in Medical Psychology, and frequently contributed articles to Winslow's Psychological Journal. He had no difficulty in clothing his sentiments in flowing and elegant language. In his paper on Guiteau he advocated the view that he was insane. His articles on "Mad Poets" are pleasant reading.

DANIEL NOBLE, M.D., F.R.C.P.

Dr. Noble was at one time prominently before the public as a writer on Psychological Medicine and allied subjects. It is so long since he wrote any work that he is in danger of being forgotten. His "Elements of Psychological Medicine" possessed no small merit, though severely criticised by the late Professor Laycock in a medical periodical. In "The Brain and its Physiology," Dr. Noble entered into a minute defence of the phrenological system, and threw fresh life into it by his vigorous style and his able mode of handling it. The most striking and important contribution, however, was his "Mesmerism True—Mesmerism False," which appeared in Forbes's "British and Foreign Medico-Chirurgical Review" in 1845, and was generally supposed to be from the editor's brilliant pen. At the present day it would probably not command particular attention, and would, it is likely, be thought to err on the side of scepticism; but forty years ago it was a bold, though discriminating, advocacy of what was really true in mesmerism, and was entirely free from indulging in the ignorant vulgar tirade against everything passing under the name, which at that period disgracefully characterised the treatment of the subject by the medical journals. In Dr. Noble, Sir John Forbes recognised one of his ablest and most intelligent contributors. Among his other works were "The Human Mind in its Relations with the Brain and Nervous System;" and "Influence of Manufactures upon Health and Life."

Dr. Noble died at Manchester January 12, aged 75.

Appointments.

COCKS, HORACE, M.B., C.M.Ed., appointed Junior Assistant Medical Officer to the Norfolk County Asylum, Thorpe, near Norwich.

JOHNSTON, M., M.R.C.S., L.R.C.P., L.M.Lond., appointed Junior Assistant Medical Officer to the Sussex County Lunatic Asylum, Haywards Heath.

NORMAN, CONOLLY, M.K.Q.C.P.I., F.R.C.S.I., appointed Resident Medical Superintendent to the Monaghan County Lunatic Asylum.

WALKER, E. B. C., M.B., C.M.Ed., promoted Senior Assistant Medical Officer to the Sussex County Lunatic Asylum, Haywards Heath.

WORTHINGTON, THOS. B., B.A., M.D., T.C.D., appointed Medical Superintendent to the Hants County Asylum, Knowle, Fareham, *vice* Dr. Manley resigned.

SCHOLES, R. BATTERSBY, M.B., C.M.Ed., appointed Inspector of Asylms for the Insane, Queensland. Also Superintendent of the Hospitals for the Insane at Goodna and Sandy Gallop, Queensland.

SMITH, R. PERCY, M.D., M.R.C.S., appointed Assistant Medical Officer to Bethlem Royal Hospital.

PRIZE DISSERTATIONS.

Competitors for the present year are requested to forward these to the President, Dr. H. Rayner, The Asylum, Hanwell, W., on or before 30th June next. The conditions of the competition are printed in the "Journal of Mental Science" for 1883, at p. 664.

THE ANNUAL MEETING.

The Annual Meeting will be held at Cork on Tuesday, 4th August. Members intending to be present are requested to send their names as early as possible to the Secretary for Ireland, Dr. Maziere Courtenay, District Asylum, Limerick.

INDEX MEDICO-PSYCHOLOGICUS.*

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* We greatly regret to observe that the "American Index Medicus" has been discontinued. Such an enterprise deserved a better fate. The death of the publisher appears to have hastened the discontinuance of this useful work. This Association at once responded to the appeal made some time ago for help, and not only subscribed to the Index, but guaranteed to pay a certain sum towards the expenses. But it seems that a sufficient number did not pursue the same course. Hence its lamented demise.

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THE JOURNAL OF MENTAL SCIENCE.

[Published by Authority of the Medico-Psychological Association]

No. 134. NEW SERIES,
No. 98.

JULY, 1885.

VOL. XXXI.

PART 1.—ORIGINAL ARTICLES.

The Narrative of Mr. H., the Portrait-painter, Analysed and Critically Examined.* By W. A. GUY, M.D., F.R.S., &c.

In my work on "The Factors of the Unsound Mind" † I gave a condensed account of the case of Mr. H. as forwarded to Charles Dickens, editor of "All the Year Round," now nearly a quarter of a century ago, and published by him in No. 128 of that Journal, October 5th, 1861.‡ It is headed "Mr. H.'s Own Narrative," and it was forwarded to the editor, much to his surprise, in correction of the first of "Four Stories" published in an earlier number. That it is a genuine narrative, and no fiction, I have every reason to believe.

Mr. H. gave his own name, and wrote from his own studio in London. He authorised the publication of the true version written by himself, and he corrected the proofs. The editor prevailed on Mr. H. to present his narrative without any introductory remarks, and he is careful to add that "no one" had for "a moment stood between the editor and his correspondent."

On this narrative I put my own interpretation, with which I was, and continue to be, satisfied. But as, in the four years that have elapsed since the publication of "The Factors," the narrative has been more than once referred to in print, and the name of its author is no longer concealed, it has occurred to me that I am in some sense bound to refer to the original document, and insist afresh on the value

* There is no longer any necessity for concealing the name of the author of the narrative, for it has been mentioned more than once as that of the late Mr. Heaphy, a London painter.

† "The Factors of the Unsound Mind, with Special Reference to the Plea of Insanity in Criminal Cases and the Amendment of the Law." By William A. Guy, M.B. Cantab, F.R.C.P., F.R.S., &c., &c. Thomas de la Rue and Co., 1881.

‡ I see that by inadvertence the date given at p. 33 of "The Factors" is 1851 instead of 1861.

of the case as illustrating a singular phase of the Unsound Mind.

In considering the course to be adopted in dealing with the "Narrative" I have asked myself the question whether it would be allowable to condense it, or whether it ought to be printed word for word as Mr. Heaphy supplied it to the editor of "All the Year Round." I decided on the second of the two alternatives, fearing lest it might be objected to any abbreviation, however carefully made, that it had omitted something essential to the formation of a sound opinion upon it and its teachings.

Having decided in favour of the publication of the document *in extenso*, another question presented itself for solution: Would it be desirable to divide the "Narrative" into parts or sections, in order to assist the reader in fully appreciating its contents, and would there be any objection to indicate, by appropriate headings to the sections, what he might expect to find in each of them? I decided that there would be no valid objection to the latter procedure, and have accordingly adopted it.

§ 1. *In the Studio—An Entertainment, and a Visit from Mr. and Mrs. Kirkbeck.*—Mr. Heaphy's narrative commences thus:—

"I am a painter. One morning in May, 1858, I was seated in my studio at my usual occupation. At an earlier hour than that at which visits are usually made, I received one from a friend whose acquaintance I had made some year or two previously in Richmond Barracks, Dublin. My acquaintance was a captain in the 3rd West York Militia, and from the hospitable manner in which I had been received while a guest with that regiment, as well as from the intimacy that existed between us personally, it was incumbent on me to offer my visitor suitable refreshments; consequently, two o'clock found us well occupied in conversation, cigars, and a decanter of sherry. About that hour a ring at the bell reminded me of an engagement I had made with a model, or a young person who, having a pretty face and neck, earned a livelihood by sitting for them to artists. Not being in the humour for work, I arranged with her to come on the following day, promising, of course, to remunerate her for her loss of time, and she went away. In about five minutes she returned, and, speaking to me privately, stated that she had looked forward to the money for the day's sitting, and

would be inconvenienced by the want of it; would I let her have a part? There being no difficulty on this point, she again went. Close to the street in which I live there is another of a very similar name, and persons who are not familiar with my address often go to it by mistake. The model's way lay directly through it, and, on arriving there, she was accosted by a lady and gentleman, who asked if she could inform them where I lived? They had forgotten my right address, and were endeavouring to find me by inquiring of persons whom they met; in a few more minutes they were shown into my room.

"My new visitors were strangers to me. They had seen a portrait I had painted, and wished for likenesses of themselves and their children. The price I named did not deter them, and they asked to look round the studio to select the style and size they should prefer. My friend of the 3rd West York, with infinite address and humour, took upon himself the office of showman, dilating on the merits of the respective works in a manner that the diffidence that is expected in a professional man when speaking of his own productions would not have allowed me to adopt. The inspection proving satisfactory, they asked whether I could paint the pictures at their house in the country, and there being no difficulty on this point, an engagement was made for the following autumn, subject to my writing to fix the time when I might be able to leave town for the purpose. This being adjusted, the gentleman gave me his card, and they left. Shortly afterwards my friend went also, and on looking for the first time at the card left by the strangers, I was somewhat disappointed to find that though it contained the name of Mr. and Mrs. Kirkbeck, there was no address. I tried to find it by looking at the Court Guide, but it contained no such name, so I put the card in my writing-desk, and forgot for a time the entire transaction."

Everything in this section of the "Narrative" is quite consistent with the idea of reality. All may have really occurred as stated. All the personages brought upon the stage may have been real, as their reported words and acts are natural under the circumstances. No hint is given of mysterious entrances or exits. There is nothing shadowy about the account, nothing to raise even a suspicion that the whole, or any part of it, was, to use our modern phraseology, subjective and not objective. I proceed, then, without further comment, to

§ 2. *A Dinner Party at a Country House—The Kirkbecks again.*

“Autumn came, and with it a series of engagements I had made in the north of England. Towards the end of September, 1858, I was one of a dinner-party at a country-house on the confines of Yorkshire and Lincolnshire. Being a stranger to the family, it was by a mere accident that I was at the house at all. I had arranged to pass a day and a night with a friend in the neighbourhood, who was intimate at the house, and had received an invitation; and the dinner occurring on the evening in question, I had been asked to accompany him. The party was a numerous one, and as the meal approached its termination, and was about to subside into the dessert, the conversation became general. I should here mention that my hearing is defective; at some times more so than at others, and on this particular evening I was extra deaf—so much so, that the conversation only reached me in the form of a continued din. At one instant, however, I heard a word distinctly pronounced, though it was uttered by a person at a considerable distance from me, and that word was—Kirkbeck. In the business of the London season I had forgotten all about the visitors of the spring, who had left their card without the address. The word reaching me under such circumstances, arrested my attention, and immediately recalled the transaction to my remembrance. On the first opportunity that offered, I asked a person whom I was conversing with if a family of the name in question was resident in the neighbourhood. I was told, in reply, that a Mr. Kirkbeck lived at A——, at the farther end of the county. The next morning I wrote to this person, saying that I believed he called at my studio in the spring, and had made an arrangement with me, which I was prevented fulfilling by there being no address on his card; furthermore, that I should shortly be in his neighbourhood on my return from the north, but should I be mistaken in addressing him, I begged he would not trouble himself to reply to my note. I gave as my address, The Post-office, York. On applying there three days afterwards, I received a note from Mr. Kirkbeck, stating that he was very glad he had heard from me, and that if I would call on my return, he would arrange about the pictures; he also told me to write a day before I proposed coming, that he might not otherwise engage himself. It was ultimately arranged that I should go to his house the succeeding Saturday, stay till Monday morning,

transact afterwards what matters I had to attend to in London, and return in a fortnight to execute the commissions."

Here we have the first ground of suspicion that we are dealing with a person liable to illusions of the senses. His hearing is "defective," and on this evening he is "extra deaf," and the conversation reaches him in the form of a "continued din." But "at one instant" he hears "distinctly pronounced," though uttered by a person at a considerable distance, the word *Kirkbeck*. I take this utterance, under the circumstances described, to have been an illusion of the sense of hearing, and having the exceptional distinctness which so often characterises the illusions of the insane. Carried back to the visit to the studio described in Section 2, and forward to occurrences yet to be detailed, it suggests the inquiry whether the Mr. and Mrs. Kirkbeck who visited the studio in May, 1858, may not have been as unreal as the name itself; the captain of militia and amateur showman of the artist's works, the model, the wine and tobacco, having or not having a real existence, but being of no importance in our judgment of the case. They may have played the part of a real setting to an unreal picture existing only in the brain of the artist. But, be this as it may, I have no hesitation in pronouncing the name Kirkbeck, as uttered at the party under the circumstances described, as an illusion* of the hearing, affording a presumption that the person the subject of this form of unreality might also be subject to illusions of the senses of sight and touch.

§ 3. *The Railway Journey from York to London—The Lady Companion—The Conversation.*

"The day having arrived for my visit, directly after breakfast I took my place in the morning train from York to London. The train would stop at Doncaster, and after that at Retford junction, where I should have to get out in order to take the line through Lincoln to A——. The day was cold, wet, foggy, and in every way as disagreeable as I had ever known a day to be in an English October. The carriage in which I was seated had no other occupant than myself, but at Doncaster a lady got in. My place was back to the engine and next to the door. As that is considered the

* As the term "hallucination" is more usually employed in such a case, I may say that I use that of "illusion" intentionally, in conformity with the statement made in the "Factors of the Unsound Mind," &c., p. 3.

ladies' seat, I offered it to her; she, however, very graciously declined it, and took the corner opposite, saying, in a very agreeable voice, that she liked to feel the breeze on her cheek. The next few minutes were occupied in locating herself. There was the cloak to be spread under her, the skirts of the dress to be arranged, the gloves to be tightened, and such other trifling arrangements of plumage as ladies are wont to make before settling themselves comfortably at church or elsewhere, the last and most important being the placing back over her hat the veil that concealed her features. I could then see that the lady was young, certainly not more than two or three-and-twenty; but being moderately tall, rather robust in make, and decided in expression, she might have been two or three years younger. I suppose that her complexion would be termed a medium one; her hair being of a bright brown, or auburn, while her eyes and rather decidedly marked eyebrows were nearly black. The colour of her cheek was of that pale transparent hue that sets off to such advantage large expressive eyes, and an equable firm expression of mouth. On the whole, the ensemble was rather handsome than beautiful, her expression having that agreeable depth and harmony about it that rendered her face and features, though not strictly regular, infinitely more attractive than if they had been modelled upon the strictest rules of symmetry.

"It is no small advantage on a wet day and a dull long journey to have an agreeable companion, one who can converse, and whose conversation has sufficient substance in it to make one forget the length and the dreariness of the journey. In this respect I had no deficiency to complain of, the lady being decidedly and agreeably conversational. When she had settled herself to her satisfaction, she asked to be allowed to look at my Bradshaw, and not being a proficient in that difficult work, she requested my aid in ascertaining at what time the train passed through Retford again on its way back from London to York. The conversation turned afterwards on general topics, and, somewhat to my surprise, she led it into such particular subjects as I might be supposed to be more especially familiar with; indeed, I could not avoid remarking that her entire manner, while it was anything but forward, was that of one who had either known me personally or by report. There was in her manner a kind of confidential reliance when she listened to me that is not usually accorded to a stranger, and sometimes she

actually seemed to refer to different circumstances with which I had been connected in times past. After about three-quarters of an hour's conversation the train arrived at Retford, where I was to change carriages. On my alighting and wishing her good-morning, she made a slight movement of the hand as if she meant me to shake it, and on my doing so she said, by way of adieu, 'I dare say we shall meet again;' to which I replied, 'I hope that we shall all meet again,' and so parted, she going on the line towards London and I through Lincolnshire to A——. The remainder of the journey was cold, wet, and dreary. I missed the agreeable conversation, and I tried to supply its place with a book I had brought with me from York, and the 'Times' newspaper, which I had procured at Retford. But the most disagreeable journey comes to an end at last, and half-past five in the evening found me at the termination of mine. A carriage was waiting for me at the station, where Mr. Kirkbeck was also expected by the same train, but as he did not appear it was concluded he would come by the next—half an hour later; accordingly, the carriage drove away with myself only.

"The family being from home at the moment, and the dinner hour being seven, I went at once to my room to unpack and to dress; having completed these operations, I descended to the drawing-room. It probably wanted some time to the dinner hour, as the lamps were not lighted, but in their place a large blazing fire threw a flood of light into every corner of the room, and more especially over a lady who, dressed in deep black, was standing by the chimney-piece warming a very handsome foot on the edge of the fender. Her face being turned away from the door by which I had entered, I did not at first see her features; on my advancing into the middle of the room, however, the foot was immediately withdrawn, and she turned round to accost me, when, to my profound astonishment, I perceived that it was none other than my companion in the railway carriage. She betrayed no surprise at seeing me; on the contrary, with one of those agreeable joyous expressions that make the plainest woman appear beautiful, she accosted me with, 'I said we should meet again.'"

There are details in this part of the "Narrative" which give such an air of reality to the whole as would naturally mislead those who have no experience of the unsound mind. But, at the same time, there are indications that it is not a

real person with whom he is conversing, but his own brain that is supplying facts from his own history. He is somewhat surprised to find that she led the conversation into subjects with which he might be supposed to be specially familiar. He could not help remarking that her entire manner was that of one who had known him either personally or by report; and she actually seemed to refer to circumstances with which he had been connected in times past. Thus does the brain embody its own memories in the phantoms of its own creation, as did Clare, the Northamptonshire poet and certified madman, transfer to the lips of the spectral lady whom he took for the governess of the mansion he was visiting the burning words of his own poetry.* It is noticeable that Mr. Kirkbeck, though expected by the same train as the author of the "Narrative," did not make his appearance, but that a carriage was in waiting which conveyed him to his house, where, having dressed for dinner, he descended to the drawing-room, where a lady, standing before a blazing fire, as described, on turning her face towards him, stands confessed as the companion of his railway journey. It is easy to understand Mr. Heaphy's "profound astonishment" when, in the evening of this same day, he again encountered his "companion" of the railway journey, betraying no surprise, assuming an "agreeable joyous expression," and accosting him with the words, "I said we should meet again." Again the painter's creative brain, out of its own wonderful resources, had conjured up person, voice, and manner.

§ 4. *Puzzled and Perplexed—Again the "Lady in Black."*

We now learn for the first time that the phantom-lady wore a black dress, and henceforth I shall speak of her as "*the lady in black.*" The "Narrative" continues thus:—

"My bewilderment at the moment almost deprived me of utterance. I knew of no railway or other means by which she could have come. I had certainly left her in a London train, and had seen it start, and the only conceivable way in which she could have come was by going on to Peterborough and then returning by a branch to A——, a circuit of about ninety miles. As soon as my surprise enabled me to speak, I said that I wished I had come by the same conveyance as herself.

"'That would have been rather difficult,' she rejoined."

Once more "bewilderment" almost depriving the seer of

* "Factors of the Unsound Mind," p. 36.

“utterance,” but not of all reasoning faculty; for that expressed itself in the words transferred to her lips: “That would have been rather difficult.”

§ 5. *The Question of the Portrait.*

“At this moment the servant came with the lamps, and informed me that his master had just arrived and would be down in a few minutes.

“The lady took up a book containing some engravings, and having singled one out (a portrait of Lady —), asked me to look at it well and tell her whether I thought it like her.

“I was engaged trying to get up an opinion, when Mr. and Mrs. Kirkbeck entered, and shaking me heartily by the hand, apologised for not being at home to receive me; the gentleman ending by requesting me to take Mrs. Kirkbeck in to dinner.

“The lady of the house having taken my arm, we marched on. I certainly hesitated a moment to allow Mr. Kirkbeck to pass on first with the mysterious lady in black, but Mrs. Kirkbeck not seeming to understand it, we passed on at once. The dinner-party consisting of us four only, we fell into our respective places at the table without difficulty, the mistress and master of the house at the top and bottom, the lady in black and myself on each side. The dinner passed much as is usual on such occasions. I, having to play the guest, directed my conversation principally, if not exclusively, to my host and hostess, and I cannot call to mind that I or anyone else once addressed the lady opposite. Seeing this, and remembering something that looked like a slight want of attention to her on coming into the dining-room, I at once concluded that she was the governess. I observed, however, that she made an excellent dinner; she seemed to appreciate both the beef and the tart as well as a glass of claret afterwards; probably she had had no luncheon, or the journey had given her an appetite.

“The dinner ended, the ladies retired, and after the usual port, Mr. Kirkbeck and I joined them in the drawing-room. By this time, however, a much larger party had assembled. Brothers and sisters-in-law had come in from their residences in the neighbourhood, and several children, with Miss Hardwick, their governess, were also introduced to me. I saw at once that my supposition as to the lady in black being the governess was incorrect. After passing the time necessarily occupied in complimenting the children, and saying some-

thing to the different persons to whom I was introduced, I found myself again engaged in conversation with the lady of the railway carriage, and as the topic of the evening had referred principally to portrait-painting, she continued the subject.

“‘Do you think you could paint my portrait?’ the lady inquired.

“‘Yes, I think I could, if I had the opportunity.’

“‘Now, look at my face well; do you think you should recollect my features?’

“‘Yes, I am sure I should never forget your features.’

“‘Of course I might have expected you to say that; but do you think you could do me from recollection?’

“‘Well, if it be necessary, I will try; but can’t you give me any sittings?’

“‘No, quite impossible; it could not be. It is said that the print I showed to you before dinner is like me; do you think so?’

“‘Not much,’ I replied; ‘it has not your expression. If you can give me only one sitting, it would be better than none.’

“‘No; I don’t see how it could be.’

“The evening being by this time rather far advanced, and the chamber candles being brought in, on the plea of being rather tired, she shook me heartily by the hand, and wished me good-night.”

It may be inferred from what is said in the “Narrative” of Mr. and Mrs. Kirkbeck’s behaviour on entering the dining-room that they were not conscious of the presence of a mysterious “lady in black,” and it may also be inferred that for them the seat opposite Mr. Heaphy was empty. For it is scarcely conceivable that, if it had been occupied by the governess, he should not have recollected that she, the fourth of a small party of four, was not once addressed by himself or his host. The idea that she was the governess being afterwards set aside by the appearance in the drawing-room of Miss Hardwick, the real governess, to whom he was introduced, having shown him his mistake, he resumes his conversation with the “lady of the railway carriage,” who must have been his opposite neighbour at dinner, though the fact is hardly directly stated. I may observe in passing that an air of reality is imparted to her by what is said of the excellent and appreciative dinner for which her journey had given her an appetite, as well as by the hearty shake of the hand with

which she took leave of him for the night. I infer, then, from what I have just stated, that the lady who sat opposite to Mr. Heaphy at dinner was no other than the lady whom he terms sometimes "the lady in black," sometimes "the lady of the railway carriage." In the course of conversation about the portrait, what the lady says of the impossibility of giving the artist a sitting is worthy of a passing remark.

§ 6. *Night-thoughts—Again Puzzled and Perplexed—Conclusive Testimony of the Servant and of Mr. and Mrs. Kirkbeck.*

"My mysterious acquaintance caused me no small pondering during the night. I had never been introduced to her, I had not seen her speak to anyone during the entire evening, not even to wish them good-night—how she got across the country was an inexplicable mystery. Then, why did she wish me to paint her from memory, and why could she not give me even one sitting? Finding the difficulties of a solution to these questions rather increase upon me, I made up my mind to defer further consideration of them till breakfast-time, when I supposed the matter would receive some elucidation.

"The breakfast now came, but with it no lady in black. The breakfast over, we went to church, came home to luncheon, and so on through the day, but still no lady, neither any reference to her. I then concluded that she must be some relative, who had gone away early in the morning to visit another member of the family living close by. I was much puzzled, however, by no reference whatever being made to her, and finding no opportunity of leading any part of my conversation with the family towards the subject, I went to bed the second night more puzzled than ever. On the servant coming in in the morning, I ventured to ask him the name of the lady who dined at the table on the Saturday evening, to which he answered —

"‘A lady, sir? No lady, only Mrs. Kirkbeck, sir.’

"‘Yes, the lady that sat opposite me dressed in black?’

"‘Perhaps, Miss Hardwick, the governess, sir?’

"‘No, not Miss Hardwick; she came down afterwards.’

"‘No lady as I see, sir.’

"‘Oh dear me, yes, the lady dressed in black that was in the drawing-room when I arrived, before Mr. Kirkbeck came home?’

"The man looked at me with surprise as if he doubted my

sanity, and only answered, ‘I never see any lady, sir,’ and then left.

“The mystery now appeared more impenetrable than ever—I thought it over in every possible aspect, but could come to no conclusion upon it. Breakfast was early that morning in order to allow of my catching the morning train for London. The same cause also slightly hurried us, and allowed no time for conversation beyond that having direct reference to the business that brought me there; so, after arranging to return to paint the portraits on that day three weeks, I made my adieus, and took my departure for town.

“It is only necessary for me to refer to my second visit to that house, in order to state that I was assured most positively, both by Mr. and Mrs. Kirkbeck, that no fourth person dined at the table on the Saturday evening in question. Their recollection was clear on the subject, as they had debated whether they should ask Miss Hardwick, the governess, to take the vacant seat, but had decided not to do so; neither could they recall to mind any such person as I described in the whole circle of their acquaintance.”

The “mysterious lady in black,” “the lady in the railway carriage,” does not present herself at breakfast, and Mr. Heaphy concludes that she has made an early visit to some other member of the family living close by. At night and the night following all these strange occurrences caused Mr. Heaphy “no small pondering.” He can reason upon them; can note the fact that he had never been introduced to the lady; that he had not seen her speak to any one during the evening, not even to wish them good-night. Her getting across the country from the railway station where he left her to the Kirkbecks was an “inexplicable mystery,” and her refusal of a sitting a thing hard to understand. He returns to town with the mystery unsolved.

§ 7. *In the Studio—The Lady of the Railway Carriage Again—An Engraving.*

“Some weeks passed. It was close upon Christmas. The light of a short winter day was drawing to a close, and I was seated at my table, writing letters for the evening post. My back was towards the folding-doors leading into the room in which my visitors usually waited. I had been engaged some minutes in writing, when, without hearing or seeing anything, I became aware that a person had come through the folding-doors, and was then standing beside me. I turned,

and beheld the lady of the railway carriage. I suppose that my manner indicated that I was somewhat startled, as the lady, after the usual salutation, said, 'Pardon me for disturbing you. You did not hear me come in.' Her manner, though it was more quiet and subdued than I had known it before, was hardly to be termed grave, still less sorrowful. There was a change, but it was that kind of change only which may often be observed from the frank impulsiveness of an intelligent young lady, to the composure and self-possession of that same young lady when she is either betrothed or has recently become a matron. She asked me whether I had made any attempt at a likeness of her. I was obliged to confess that I had not. She regretted it much, as she wished one for her father. She had brought an engraving (a portrait of Lady M. A.) with her that she thought would assist me. It was like the one she had asked my opinion upon at the house in Lincolnshire. It had always been considered very like her, and she would leave it with me. Then (putting her hand impressively on my arm) she added, 'She really would be most thankful and grateful to me if I would do it' (and, if I recollect rightly, she added), '*as much depended on it.*' Seeing she was so much in earnest, I took up my sketch-book, and by the dim light that was still remaining began to make a rapid pencil sketch of her. On observing my doing so, however, instead of giving me what assistance she was able, she turned away under pretence of looking at the pictures around the room, occasionally passing from one to another so as to enable me to catch a momentary glimpse of her features. In this manner I made two hurried but rather expressive sketches of her, which being all that the declining light would allow me to do, I shut my book, and she prepared to leave. This time, instead of the usual 'Good-morning,' she wished me an impressively pronounced 'Good-bye,' firmly holding rather than shaking my hand while she said it. I accompanied her to the door, outside of which she seemed rather to fade into the darkness than to pass through it. But I refer this impression to my own fancy.

"I immediately inquired of the servant why she had not announced the visitor to me. She stated that she was not aware there had been one, and that anyone who had entered must have done so when she had left the street door open about half an hour previously, while she went across the road for a moment."

The visitor on this occasion is the same lady with a more grave and composed manner, who enters noiselessly through the folding-doors and stands beside him. For the first time she mentions her father, for whom she wished to procure a portrait of herself; and she gives him as an aid an engraving like the one they had seen at the Kirkbecks. It had always been thought like her; she would be most grateful to him if he would do it; and he thinks she added that "*much depended on it.*" Nevertheless, while he was making two hurried sketches of her she, with strange inconsistency, kept turning away from him to look at the pictures in the room. She then takes him by the hand, which she holds firmly in hers, and bids him an impressive "good-bye." He accompanies her to the door, "outside of which she seemed rather to fade into the darkness than to pass through it." But, he adds, "I refer this impression to my own fancy." It was thus that John Clare's supposed governess seemed to him to vanish into the wood.*

§ 8. *Another Railway Journey—At mine Inn—A Mistake and a Letter.*

"Soon after this occurred I had to fulfil an engagement at a house near Bosworth Field, in Leicestershire. I left town on a Friday, having sent some pictures, that were too large to take with me, by the luggage train a week previously, in order that they might be at the house on my arrival, and occasion me no loss of time in waiting for them. On getting to the house, however, I found that they had not been heard of, and on inquiring at the station, it was stated that a case similar to the one I described had passed through and gone on to Leicester, where it probably still was. It being Friday, and past the hour for the post, there was no possibility of getting a letter to Leicester before Monday morning, as the luggage office would be closed there on the Sunday; consequently, I could in no case expect the arrival of the pictures before the succeeding Tuesday or Wednesday. The loss of three days would be a serious one; therefore to avoid it, I suggested to my host that I should leave immediately to transact some business in South Staffordshire, as I should be obliged to attend to it before my return to town, and if I could see about it in the vacant interval thus thrown upon my hands, it would be saving me the same amount of time after my visit to his house was concluded. This arrange-

* "*Factors of the Unsound Mind,*" p. 36.

ment meeting with his ready assent, I hastened to the Atherstone station on the Trent Valley Railway. By reference to Bradshaw, I found that my route lay through L—, where I was to change carriages, to S—, in Staffordshire. I was just in time for the train that would put me down at L— at eight in the evening, and a train was announced to start from L— for S— at ten minutes after eight, answering, as I concluded, to the train in which I was about to travel. I therefore saw no reason to doubt but that I should get to my journey's end the same night; but on my arriving at L— I found my plans entirely frustrated. The train arrived punctually, and I got out intending to wait on the platform for the arrival of the carriages for the other line. I found, however, that though the two lines crossed at L—, they did not communicate with each other, the L— station on the Trent Valley line being on one side of the town, and the L— station on the South Staffordshire line on the other. I also found that there was not time to get to the other station so as to catch the train the same evening; indeed, the train had just that moment passed on a lower level beneath my feet, and to get to the other side of the town, where it would stop for two minutes only, was out of the question. There was, therefore, nothing for it but to put up at the Swan Hotel for the night. I have an especial dislike to passing an evening at an hotel in a country town. Dinner at such places I never take, as I had rather go without than have such as I am likely to get. Books are never to be had, the country newspapers do not interest me. The 'Times' I had spelt through on my journey. The society I am likely to meet have few ideas in common with myself. Under such circumstances, I usually resort to a meat tea to while away the time, and when that is over, occupy myself in writing letters.

"This was the first time I had been in L—, and while waiting for the tea, it occurred to me how, on two occasions within the past six months, I had been on the point of coming to that very place, at one time to execute a small commission for an old acquaintance, resident there, and another, to get the materials for a picture I proposed painting of an incident in the early life of Dr. Johnson. I should have come on each of these occasions had not other arrangements diverted my purpose and caused me to postpone the journey indefinitely. The thought, however, would occur to me, 'How strange! Here I am at L—, by no intention

of my own, though I have twice tried to get here and been balked.' When I had done tea, I thought I might as well write to an acquaintance I had known some years previously, and who lived in the Cathedral-close, asking him to come and pass an hour or two with me. Accordingly, I rang for the waitress and asked —

" 'Does Mr. Lute live in Lichfield ?' "

" 'Yes, sir.' "

" 'Cathedral-close ?' "

" 'Yes, sir.' "

" 'Can I send a note to him ?' "

" 'Yes, sir.' "

Again we have a perplexing railway journey, and, as we shall presently see, another mistake as to names, with a result which, after all that we have seen, need not surprise us. Two other personages, perhaps as unreal as the "lady in the railway carriage," appear upon the scene, anxious also to procure a likeness.

§ 9. *The Lutes—The Unsuccessful Portrait.*

"I wrote the note, saying where I was, and asking if he would come for an hour or two and talk over old matters. The note was taken; in about twenty minutes a person of gentlemanly appearance, and what might be termed the advanced middle age, entered the room with my note in his hand, saying that I had sent him a letter, he presumed, by mistake, as he did not know my name. Seeing instantly that he was not the person I intended to write to, I apologised, and asked whether there was not another Mr. Lute living in L—— ?

" 'No, there was none other.' "

" 'Certainly,' I rejoined, 'my friend must have given me his right address, for I had written to him on other occasions here. He was a fair young man, he succeeded to an estate in consequence of his uncle having been killed while hunting with the Quorn hounds, and he married about two years since a lady of the name of Fairbairn.' "

"The stranger very composedly replied, 'You are speaking of Mr. Clyne; he did live in the Cathedral-close, but he has now gone away.' "

"The stranger was right, and in my surprise I exclaimed —

" 'Oh dear, to be sure, that is the name; what could have made me address you instead ? I really beg your pardon; my writing to you, and unconsciously guessing your name,

is one of the most extraordinary and unaccountable things I ever did. Pray pardon me.'

"He continued very quietly —

"'There is no need of apology; it happens that you are the very person I most wished to see. You are a painter, and I want you to paint a portrait of my daughter; can you come to my house immediately for the purpose?'

"I was rather surprised at finding myself known by him, and the turn matters had taken being so entirely unexpected, I did not at the moment feel inclined to undertake the business; I therefore explained how I was situate, stating that I had only the next day and Monday at my disposal. He, however, pressed me so earnestly that I arranged to do what I could for him in those two days, and having put up my baggage, and arranged other matters, I accompanied him to his house. During the walk home he scarcely spoke a word, but his taciturnity seemed only a continuance of his quiet composure at the inn. On our arrival he introduced me to his daughter Maria, and then left the room. Maria Lute was a fair and a decidedly handsome girl of about fifteen; her manner was, however, in advance of her years, and evinced that self-possession, and, in the favourable sense of the term, that womanliness, that is only seen at such an early age in girls that have been left motherless, or from other causes thrown much on their own resources.

"She had evidently not been informed of the purpose of my coming, and only knew that I was to stay there for the night; she therefore excused herself for a few moments, that she might give the requisite directions to the servants as to preparing my room. When she returned, she told me that I should not see her father again that evening, the state of his health having obliged him to retire for the night; but she hoped I should be able to see him some time on the morrow. In the meantime, she hoped I would make myself quite at home, and call for anything I wanted. She, herself, was sitting in the drawing-room, but perhaps I should like to smoke and take something; if so, there was a fire in the housekeeper's room, and she would come and sit with me, as she expected the medical attendant every minute, and he would probably stay to smoke, and take something. As the little lady seemed to recommend this course, I readily complied. I did not smoke, or take anything, but sat down by the fire, when she immediately joined me. She conversed well and readily, and with a command of language singular

in a person so young. Without being disagreeably inquisitive, or putting any question to me, she seemed desirous of learning the business that had brought me to the house. I told her that her father wished me to paint either her portrait or that of a sister of hers, if she had one.

“She remained silent and thoughtful for a moment, and then seemed to comprehend it at once. She told me that a sister of hers, an only one, to whom her father was devotedly attached, died near four months previously; that her father had never yet recovered from the shock of her death. He had often expressed the most earnest wish for a portrait of her; indeed, it was his one thought, and she hoped, if something of the kind could be done, it would improve his health. Here she hesitated, stammered, and burst into tears. After a while she continued: ‘It is no use hiding from you what you must very soon be aware of. Papa is insane—he has been so ever since dear Caroline was buried. He says he is always seeing dear Caroline, and he is subject to fearful delusions. The doctor says he cannot tell how much worse he may be, and that everything dangerous, like knives or razors, are to be kept out of his reach. It was necessary you should not see him again this evening, as he was unable to converse properly, and I fear the same may be the case to-morrow; but perhaps you can stay over Sunday, and I may be able to assist you in doing what he wishes. I asked whether they had any materials for making a likeness—a photograph, a sketch, or anything else for me to go from.’ ‘No, they had nothing.’ ‘Could she describe her clearly?’ She thought she could; and there was a print that was very much like her, but she had mislaid it. I mentioned that with such disadvantages, and in such an absence of materials, I did not anticipate a satisfactory result. I had painted portraits under such circumstances, but their success much depended upon the powers of description of the persons who were to assist me by their recollection; in some instances I had attained a certain amount of success, but in most the result was quite a failure. The medical attendant came, but I did not see him. I learnt, however, that he ordered a strict watch to be kept on his patient till he came again the next morning. Seeing the state of things, and how much the little lady had to attend to, I retired early to bed. The next morning I heard that her father was decidedly better; he had inquired earnestly on waking whether I was really in the house, and at breakfast-time he sent down to say that he

hoped nothing would prevent my making an attempt at the portrait immediately, and he expected to be able to see me in the course of the day.

"Directly after breakfast I set to work, aided by such description as the sister could give me. I tried again and again, but without success, or, indeed the least prospect of it. The features, I was told, were separately like, but the expression was not. I toiled on the greater part of the day with no better result. The different studies I made were taken up to the invalid, but the same answer was always returned—no resemblance. I had exerted myself to the utmost, and, in fact, was not a little fatigued by so doing—a circumstance that the little lady evidently noticed, as she expressed herself most grateful for the interest she could see I took in the matter, and referred the unsuccessful result entirely to her want of powers of description."

§ 10. *The Phantom-Print—The Successful Portrait.*

"It was so provoking! she had a print—a portrait of a lady—that was so like, but it had gone—she had missed it from her book for three weeks past. It was the more disappointing, as she was sure it would have been of such great assistance. I asked if she could tell me who the print was of, as if I knew, I could easily procure one in London. She answered, Lady M. A. Immediately the name was uttered the whole scene of the lady of the railway carriage presented itself to me. I had my sketch-book in my portmanteau upstairs, and, by a fortunate chance, fixed in it was the print in question, with the two pencil sketches. I instantly brought them down, and showed them to Maria Lute. She looked at them for a moment, turned her eyes full upon me, and said slowly, and with something like fear in her manner, 'Where did you get these?' Then quicker, and without waiting for my answer, 'Let me take them instantly to papa.'

"She was away ten minutes, or more; when she returned, her father came with her. He did not wait for salutations, but said, in a tone and manner I had not observed in him before, 'I was right all the time; it was you that I saw with her, and these sketches are from her, and from no one else. I value them more than all my possessions, except this dear child.' The daughter also assured me that the print I had brought to the house must be the one taken from the book about three weeks before, in proof of which she pointed out to me the gum marks at the back, which exactly corresponded

with those left on the blank leaf. From the moment the father saw these sketches his mental health returned.

"I was not allowed to touch either of the pencil drawings in the sketch-book, as it was feared I might injure them; but an oil picture from them was commenced immediately, the father sitting by me hour after hour, directing my touches, conversing rationally, and indeed cheerfully, while he did so. He avoided direct reference to his delusions, but from time to time led the conversation to the manner in which I had originally obtained the sketches. The doctor came in the evening, and, after extolling the particular treatment he had adopted, pronounced his patient decidedly, and he believed permanently, improved."

I do not hesitate to place at the head of this section the word *phantom-print*, for it is alleged by the writer of "the Narrative" to have been given to him by the "lady in the railway carriage," the lady of the dinner party, the shadowy visitor to the studio in town; and it is the connecting link between her, her mad father and her sensible sister. This phantom-print it was that she alleged to have been so mysteriously abstracted from the book in her possession. We are clearly walking in the land of the unreal—the land peopled by the writer's own brain. Can we wonder that Mr. Heaphy considered the unconscious guessing of Mr. Lute's name as "one of the most extraordinary and unaccountable things he ever did?"

§ 11. *A Madman's Visions.*

"The next day being Sunday, we all went to church; the father, for the first time since his bereavement. During a walk which he took with me after luncheon, he again approached the subject of the sketches, and after some seeming hesitation as to whether he should confide in me or not, said, 'Your writing to me by name, from the inn at L——, was one of those inexplicable circumstances that I suppose it is impossible to clear up. I knew you, however, directly I saw you; when those about me considered that my intellect was disordered, and that I spoke incoherently, it was only because I saw things that they did not. Since her death, I know, with a certainty that nothing will ever disturb, that at different times I have been in the actual and visible presence of my dear daughter that is gone—oftener, indeed, just after her death than latterly. Of the many times that this has occurred, I distinctly remember once seeing her in a

railway carriage, speaking to a person seated opposite; who that person was I could not ascertain, as my position seemed to be immediately behind him. I next saw her at a dinner-table, with others, and amongst those others unquestionably I saw yourself. I afterwards learnt that at that time I was considered to be in one of my longest and most violent paroxysms, as I continued to see her speaking to you, in the midst of a large assembly, for some hours. Again I saw her, standing by your side, while you were engaged in either writing or drawing. I saw her once again afterwards, but the next time I saw yourself was in the inn parlour.' ”

§ 12. *The Madman Cured.*

“The picture was proceeded with the next day, and on the day after the face was completed, and I afterwards brought it with me to London to finish.

“I have often seen Mr. L. since that period; his health is perfectly re-established, and his manner and conversation are as cheerful as can be expected within a few years of so great a bereavement.

“The portrait now hangs in his bedroom, with the print and the two sketches by the side, and written beneath is, ‘C. L., 13th September, 1858, aged 22.’ ”

This statement, so strange under all the circumstances of the case as described in the “Narrative,” is not the least wonderful of all the marvels it records.

The renewed attention and study which I have given to this singular “Narrative” have only confirmed and strengthened the impressions a first perusal had produced upon me, which impressions are clearly set forth in “The Factors” in the condensed form consistent with the character and scope of that work. In expanding them, as I now proceed to do, I find no occasion to withdraw, or even to modify, any opinion there expressed.

The author is a painter of portraits, and it is around a portrait that this weird world of wonders revolves. The lady variously described as the “lady in the railway carriage” and the “lady in black,” is in search of a portrait. She wants it for a purpose to which she attaches great importance. It is the subject of their conversation at and after the dinner party, and the motive of her visit to his studio in London. She had drawn his attention to a print before the dinner party as bearing a certain resemblance to herself, she had presented him with one that resembled it

at her visit to his studio, and this same print he produces from his pocket-book at the Lutes', and from it obtains the likeness which works so strange a cure of Mr. Lute's insanity.

Now, this lady of the railway carriage, this lady in black, this visitor to his London studio is, beyond all shadow of doubt, a subjective creation of his own brain; and so is, and must be, all that she says and does, her shakings and pressure of his hands, her gift of the print. She is an illusion in which the senses of sight, hearing, and touch are jointly implicated, and his own thoughts and recollections are transferred to her lips. In his case, the thoughts relate to a portrait; in that of the Northamptonshire poet to his own verses. He receives from his phantom a phantom portrait; John Clare has his own verses put by his own brain into the mouth of the phantom lady he takes for "the governess."

Now this phantom portrait, the present of a phantom, forms a link which connects the several appearances of the lady in black with the alleged occurrences at the house of Mr. Lute, and shows that the same state of brain which created the deceased daughter had recurred and given rise to the father and surviving sister. The portrait was a phantom picture, Mr. Lute and his daughter were like creations of a disordered brain.

As to Mr. Lute's alleged recognition of his deceased daughter in the company of Mr. Heaphy on the three occasions on which they were together, that may be looked upon as a very natural development of the story at the hands of an avowed spiritualist.

As the lady herself was a phantom product of the author's own brain Mr. Lute could not have seen them together.

Nor is this view of the case in any way weakened by the assertion with which the "narrative" closes, that the author had often seen Mr. Lute since the drawing of the successful portrait, with health and spirits restored; and the likeness of his deceased daughter hanging in his bedroom, with the print and two sketches by its side, and "C.L., 13th September, 1858, aged 22," beneath it. The portrait and the two sketches are necessarily as unreal as the print; they derive their character from it; and the statement so confidently made only serves to show that, as Mr. Heaphy had seen the phantom of the deceased daughter on three several occasions, so, from time to time, Mr. Lute himself

and the phantom print presented themselves in all their strange reality to his creative brain. The phantom print obviously determines the character of its surroundings, as it does, by fair inference, that of Mr. Lute and his daughters.

Let me here remark that the "Narrative" as forwarded to the editor of "All the Year Round," relates to events more or less real, which are alleged to have occurred during a period of time dating from May, 1858, the date of publication being October, 1861, or more than three years later; and that no attempt is made to confirm the strange statements of which the narrative consists. Mr. Lute, though living and recovered, is not asked to corroborate the strange incidents of the story by certificate or testimonials. We are dealing throughout with a story that bewilders and perplexes its author, but does not shake his faith in its truth. Is it not often thus that the creations of the brain seem to the man who has experience of them as wonderfully real, as more real than the true objects with which they are blended?

This "Narrative," as a whole, suggests certain questions, which I will briefly notice in conclusion :—

1. What part of the entire Narrative consists of real occurrences, and what of creations of the writer's brain? To this question I am quite unable to give a satisfactory answer. But I have little doubt that Mr. Heaphy travelled twice by rail, encountering in the first journey the phantom "lady in black," and in the second, weaving into a connected narrative, based wholly on what he thought he saw and heard, the strange statements relating to Mr. Lute and his two daughters.

2. Assuming that the railway journeys really took place, I am disposed to answer the question, Did the fatigue and peculiar vibratory motion of the railway-carriage predispose Mr. Heaphy to the seeing, hearing, and feeling of these phantom forms? If the visions had occurred during or after the journeys by rail, and then only, I should have answered this question, with some confidence, in the affirmative. For I have myself experienced, and on two occasions, the effect on the brain of this rapid mode of conveyance with its attendant noises and quick, perceptible vibrations. In both cases the journey by rail occupied only about four hours, with carriage drives of no great length at the two ends. In the one case I had the first bleeding at the nose that I ever experienced, and, so long as I continued in my usual health,

never had again, and on the second occasion was thrown for some time into a state which I cannot better describe than as a waking dream, a condition of incoherent thought, but without illusions.

3. Are there not some relatives or intimate friends of Mr. Heaphy now surviving who could throw a welcome light on his habits of thought, and tell us whether the "Narrative" furnishes a solitary instance of its kind, or whether he had not similar stories to tell, strangely blending the real and the unreal? May there not also be some old inhabitant or inhabitants of the Close at Lichfield who can say whether, somewhere about the year 1858 (27 years ago) there was living in the Cathedral Close a gentleman of the name of Lute, who had, at or about that time, a daughter aged 22 deceased and a daughter aged about 15 living, and who was for a while, after the death of his daughter, in a state of derangement from which he recovered? I need not indicate more precisely the questions which arise out of Mr. Heaphy's case. I am sure that I can answer for the Editors of the "Journal of Mental Science" that any trustworthy information of the kind indicated will be thankfully received and acknowledged.*

Moral or Emotional Insanity.† By D. HACK TUKE, F.R.C.P.

Most of you are aware that not many months ago the Editors of the "Journal of Mental Science" invited communications from members of the Association of which it is the organ on a subject which never loses its interest, simply because events are frequently occurring which force medical psychologists to direct their attention to it. I refer to what usually passes under the name of Moral or Emotional Insanity. The very fact that it is thus forced upon our notice proves it to be a practical, not a merely speculative question. I offer no apology, therefore, for making it the theme of my paper to-day, especially as I have not joined in the discussion which has taken place in the Journal, and which now has terminated. I say "discussion," but one of the most marked features of these communications is their essential unanimity.

* We hope that the republication of this Narrative will have this result. Where is the portrait?—[EDS.]

† This paper was read before the Section of Psychology, at the meeting of the British Medical Association held at the Queen's University, Belfast, July, 1884.

In the first place, then, one cannot disregard this unanimity, and it is the more important because these communications proceed from the superintendents of asylums or those attached to them. And it must not be forgotten that for one case of moral insanity which is sent to an asylum, scores may exist which never cross the threshold of home, or are otherwise disposed of. They may be the plague of life, the thorn in the flesh, the skeleton in the cupboard, but may never be certified as lunatics, or pass through the portals of Broadmoor. In fact, it may well be that numerous cases of moral insanity are scientifically but not legally mad, and that medical men cannot supply facts "observed by themselves" which would in the eye of the law be sufficient to warrant a medical certificate.

When we see a young lady in a family who has had the same advantages of a good education and a moral training as the rest, but who is the demon instead of the angel of the house, is an inveterate liar, a thief, and prone to startling irregularities of conduct; and when, although there is nothing in the degree of intelligence which prevents her taking her place in society like other people, there is in the close connection of the immoral acts with the evolution of the system, in the family history, or in some moral shock or traumatism, significant indications of a physical cause of this moral instability which separates it from mere vice; I say, when such a combination presents itself, we witness what every mental physician must have met with, and what we are bound to regard as abnormal and morbid, by whatever name we choose to call it.

As to the term "Moral Insanity," under which the communications I have referred to appeared, I would observe that however objectionable it may be, their writers have striven to convey their sense of there being a form of mental disorder in which there is a loss of control over the lower propensities, or in which the moral sentiments rather than the intellectual powers are confused, weakened, or perverted. The central idea and contention of these papers has been that from time to time cases occur in regard to which especial anxiety and difficulty are experienced—the prominent, characteristic, and by far the most striking and important factor of the mental condition being, not loss of memory, not delusion or hallucination, not any deficiency of talent or genius, not any lack of mental acuteness, and certainly no incoherence of ideas or language—none of

these—but a deficiency or impairment of moral feeling or self-control, such being either the development of a character natural to the individual or a departure from it, which contrasts most strikingly with its former traits. Am I not substantially correct in this description of what is aimed at by those who insist on the existence of moral madness? We may, perhaps, see our way some day to adopt a happier term to designate this condition, but whether we improve upon the term or not—whether we speak of *mania sine delirio*, or reasoning mania (*manie raisonnante*), or adopt Parigot's term, *diastrephia* (perversion)—I venture to think that the thought which so many desire to convey and clothe in some term or other, and mostly under the much-reviled term of Moral Insanity, is supported by clinical facts—and is no ignis fatuus leading mental physicians astray into the labyrinth of metaphysics. Certainly the term is unfortunate if it leads to the supposition that in all, or even in most instances, there is a disorder of the moral sentiments or emotions themselves, instead of a derangement or defect of inhibitory power and their consequent uncontrolled and irregular action. To this point I shall return.

Of the cases reported or referred to in the Journal, one had become morally insane after an attack of rheumatic fever; his temper, his habits, his feelings being changed, without intellectual weakness or delusion.

With others, uncontrollable sexual proclivities dominated the mind from infancy upwards, along with fully average intellectual ability.

Then there were examples of persistent lying without object or interest, carried to such an extent that it was impossible to regard the condition present as other than one of moral disorder.

One interesting case was that of a lady—a Eurasian—born in India, of mixed blood; and her mother, I may say, was insanely jealous. It was reported by a physician long acquainted with the family as one of emotional insanity, without definite intellectual disorder. Subject to violent outbursts of temper from childhood, in consequence of which her father predicted for her an asylum, she at last made a homicidal assault upon another lady. She was soon afterwards sent to Bethlem Hospital, where I have often seen her, and I have Dr. Savage's authority for stating that he regarded her as morally insane. Her intelligence was intact, except, indeed, that her intense jealousy, which she

inherited from her mother, coloured her estimate of others, leading her to think they were inimical to her. After being two years and a half at Bethlem, she was discharged, and is now at large.

Again, cases were referred to in which melancholia more or less profound affected an individual, without any distinct delusion—an overpowering sense of misery.

We all know the intense, baseless, unconquerable depression which falls upon a dyspeptic for a certain time without the slightest delusion or affection of the memory or reason. This condition of the feelings is one which, if continuous, would be regarded as insanity.* Here it may be urged that the man takes an utterly unreasonable estimate of life and of himself, and that therefore the intellect is involved. I reply that there can be no objection to conceding this, for the sake of peace, if the objector will only be consistent in carrying out this view. But what happens? The objector, a lawyer we will suppose, when he wishes to prove that a moral maniac is not insane and irresponsible, will not grant that a particular state of the feelings carries with it a disorder of the reason.

Think again of the terrible sense of depression produced by a drug, hyoscyamine, for example; and is it not here demonstrated by experiment that the feelings, in the sense ordinarily understood, may be acutely and irresistibly affected without the intellectual functions, as generally defined, being implicated?

One case of moral insanity recorded is that of a boy of about five years of age, who is described by an asylum superintendent of great experience as the very spirit of mischief, destructive, and constantly causing alarm in the family; yet this child, the writer adds, was “perfectly intelligent.”

Another case contributed by the same observer was that of a clever schoolboy of six, the plague of the house, who, in addition to displaying mischievous tricks, developed a homicidal propensity. Severe no less than kind treatment failed to influence him. Both these youths, it should be

* As Guislain says, “I meet every day with melancholiacs who do not exhibit any disorder in their ideas or lesion of the judgment. Melancholia is exclusively an exaggeration of the affective sentiment; it is, in all the force of its significance, a *Gemüthkrankheit*, in the sense in which the word is employed by German psychologists. It is a pathological emotion, a sadness, a chagrin, a fear or dread, and nothing more. It is not a condition which sensibly weakens the conceptive faculties.” (“*Leçons Orales*,” Vol. i., p. 112.)

added, were in a good position socially, and were kindly brought up by their parents.

Lastly, there is the case of a man in a low social position, in whom, superadded to a cunning, inferior, and unstable moral nature, drink played an important part. He was placed in an asylum, where the superintendent describes him as having an irresistible impulse to kill himself or others.

To the cases given in the Journal I will add several of my own. The descriptions must be very brief.

1. A most instructive case of temporary impulse, altogether motiveless, fell under my observation one day at a hospital in London, where a man, labouring under paralysis following fright, attended in the out-patients' room. While examining him, and ascertaining his history, he incidentally mentioned to me, as an inexplicable and horrible circumstance, that he one day experienced a sudden impulse to injure one of his children, towards whom he felt nothing but affection. Happily he was just able to control the impulse, and nothing happened; but what a significant illustration it presents of the initial stage of a homicidal impulse, which might have ended in the actual commission of an act, due obviously to cerebral disease—motion and emotion being alike disordered by the shock the nervous system had received. The man died several years afterwards, and coarse brain disease was discovered. The impulse in this case must be clearly distinguished from the irritability or passion, which occurs so frequently in paralysis, from mere loss of control. Here there was neither irritation nor passionate temper, but the simple, motiveless impulse to injure the child, as in a case I have elsewhere recorded in which a lady bitterly deplored an impulse under which she laboured to kill her boy.

2. In the next case, I find it difficult to see what legitimate objection can be made to it as an instance in point. It is one well known to me, and presented at one time the gravest difficulties, from the impossibility of laying hold of any intellectual defect upon which to take action and exercise control in order to save the patient from himself. A gentleman's son, a boy of five, favourably circumstanced in his moral surroundings, had an attack of scarlet fever. He recovered, but his moral character had undergone a remarkable change. Instead of being a truthful, he became a very untruthful lad. For a time he was honest; then he began to take what was not his own, without the slightest occasion

for doing so. A further stage was reached—he evinced a disposition to injure others. I ought to add that this attack of scarlet fever did not affect his memory in the least. On the contrary, it was remarkably good. At last he was, when a young man, placed under care, a precaution which it is almost certain averted the commission of some act which would have brought him into collision with the laws of his country. That this was not a case of vice, but of mental disorder, is, to my mind, clear, without the subsequent history of the patient, which fully confirmed the diagnosis made. The lying, the thieving, and the tendency to commit acts dangerous to others are, it is true, common to vice and disease. On the other hand, the causation, the change of character, the contrast to the boy's environment, the absence of any sufficient motive for the acts committed, marked their true nature.

3. I was consulted not long since about a young lady—and the case is one which I am sure you will not regard as a rare one—who, her parents said, rendered home simply intolerable. There was no delusion or hallucination; there was not the slightest incoherence in her conversation. She was not strong-minded, certainly, and I believe she was a dull girl when at school; but there would have been no sustainable plea on this ground had she committed a criminal act. It certainly was not on account of any intellectual defect that her family sought advice. It was because she was, at home, just so much emotional dynamite, ever liable to explode, and now and again doing so with disastrously painful consequences. When no explosion occurred, the patient's condition was frequently that of quiet sulking. Jealous, spiteful, unkind, where she ought to have been most considerate, she rendered home the reverse of happy, and there were times when it was feared that seriously unpleasant consequences might ensue. The only mode of terminating this misery was by removing the unfortunate cause from the family circle. After a time, she would be allowed to return home. At first the hope would be entertained that a new and better leaf had been turned over; but this hope was soon doomed to bitter disappointment. The moral pest was once more in the house, and the old misery was experienced, the old danger renewed. The “attercop”—the poison spider of the household—was once more at work, spinning her net with subtle industry, and poisoning family-life with ill-temper and jealousy.

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4. I possess the manuscript journal of a youth who kept it while at sea, and there is nothing to betray any intellectual aberration. Yet I believe him to have been at that time morally insane; I may say constitutionally unstable in regard to moral character. He was quick at school, but no master would keep him, and he was tossed like a shuttlecock from seminary to seminary. One of his schoolfellows informs me that the other boys thought him very clever; that he would learn his lessons in a shorter time than the rest, and then go to play. When told to go on with learning his lessons, he challenged the master to test him. The latter tells me that the boy attacked him one day when they were walking out, and hurt him severely. On another occasion he pulled out his knife and threatened to use it on any boy who offended him, and in the night he was fond of standing over a boy in bed and threatening his life with a knife. At times he would sulk, and shut himself up in an out-house while the boys were at play. Although brought up in a moral family, he was dangerous at home to the other children; he was, as we see, dangerous at school; he was untruthful; and neither discipline nor kindness made him dependable. He was, when a very young man, placed in an asylum. He did not then develop any delusion, nor exhibit weak-mindedness. He rather suddenly became paraplegic, a condition which I regarded in the first instance as hysterical in character or even feigned; but he grew worse, and died. Distinct structural changes were found. I have little doubt that if he had not been placed in an asylum he would have committed a homicidal act. It would have been impossible to prove him intellectually insane; and that he knew the nature and quality of the act of murder I have good reason to know from conversation with him. I may add that he had a brother, who was particularly intelligent, but was a dipsomaniac.

5. Quite recently I have been consulted about a patient who exactly illustrates the character of some forms of moral insanity, or whatever you prefer to call the mental condition present which led to so much difficulty and distress. A boy of eight is the subject of violent paroxysms of so-called temper, and has in consequence to be removed from the school at which he is placed. There is no distinct intellectual defect which I can discover. He has been too much pressed, however, with his lessons, and some may be disposed to argue that because he has thus suffered it shows he is weaker

intellectually than other boys, but this is not the sense in which disorder of the intellect is generally employed. And here I would, in passing, complain of the shifting sense in which the term "intellectual disorder" is used. At one time it is employed to mean downright weak-mindedness or a delusion; and this is done when an alleged lunatic's insanity is challenged on the ground that these are absent. At another time it is used when there is the very slightest mental dulness; and this course is adopted when a physician denying moral insanity, admits the individual's unsoundness, but desires to show that he is not only morally but intellectually insane. It is enough for such an advocate that the man is not very brilliant.

I heard the other day from a lady, a near relative of this boy, that his last escapade at school was on the occasion of being locked up in a room at the top of the house for some offence. When left alone, he coolly broke the window and crawled out on to the roof, an old high-pointed one without a parapet, to the horror of the authorities. His cat-like facility of springing and jumping about saved him from harm, and after exploring the roof as much as he wished, he adroitly returned to his room through the window. My informant adds that when she entreated him to be good he clutched and looked at her most earnestly, exclaiming "I can't." He slept in the same room as a boy of 13, but has now been removed as it was found that he tormented this older lad intolerably. Yet his mistress says he is for short periods so good and sweet, that although he is the torment of her life, she loves him better than any of the other boys. In the letter I have quoted, the lady says that he is the picture of health, that he is very quick, and can learn as well as any of the other boys.

The cases whose leading features have been thus briefly sketched added to those recorded in the Journal divide themselves into (1) those in which there was a constitutional defect in the normal balance between the passions and the power of moral control or will. (2) Those in which a well-marked change of character took place in regard to the disposition and the higher sentiments, whether from moral shock or from fever. This would comprise cases of sexual impulse. (3) Cases in which the emotional disorder was manifested simply by the feeling of intense depression, without the patient himself being able to formulate a definite delusion, this being the exaggeration of the natural character,

or what, I think, is more usual, the most complete contrast to it. Among the cases which have appeared in the "Journal of Mental Science" there is one in which drink was clearly an important factor in the production of the symptoms, and those whose craving for stimulants really amounts to irresistibility labour under a species of moral insanity, which may properly form a fourth division.

In the thoughtful contribution on Moral Insanity made to the Journal by Dr. Gasquet, April, 1882, he eliminates from it all cases of so-called irresistible impulse as not falling properly under this head. I shall, however, venture, with Heinroth and Prichard, to include such cases under the term, as they are generally so regarded, and it is more convenient for the practical object I have in view.

None of the cases reported in the Journal were associated with epilepsy, but I need hardly say that some of the most difficult cases of mental disorder related to crime are those in which there have been epileptic attacks at some period of a man's life, but not at the time of the alleged crime; or in which there have been no fits at all, but the character of the action, the mental symptoms, and the family history, suggest very strongly that the epilepsy is latent or veiled, such cases resembling an attack of scarlet fever without rash or even sore throat. It is only during the last few years that these cases have been clearly recognised, but the proof of their connection with epilepsy does not, it seems to me, take them out of the category of the class of affections which Prichard had in view, even though we should regard the mental symptoms present as the consequence, not of their directly exaggerated force, but of the removal for a time of the inhibitory power of the higher centres. The non-mention of epilepsy in these cases is of interest, because Westphal says he "scarcely remembers a case of moral insanity which was not connected with it." I believe that this relationship only applies to a limited, although very important, class of cases, but when it does occur, it certainly presents, as Tardieu says, the most grave and difficult problem, in regard to responsibility, which can possibly fall under the consideration of the expert.

Passing now from the clinical facts illustrative of the class of cases which have given rise to the recognition of the group of mental disorders known as moral insanity, I proceed to offer a few observations on the psychology of this form of alienation. On this aspect of the subject Dr. Savage has

already touched briefly in his contribution to the *Journal*, July, 1881, but it is so important, and as Herbert Spencer says in a letter I have recently received from him, "so involved," that I desire to call attention to it on this occasion.

I have said that the term *Moral Insanity* is unfortunate so far as it leads persons to think that *Feeling* is itself always the primary seat of disease, while the other mental functions are healthy. It is very certain, on the contrary, that what happens is oftentimes only a weakening of the higher centres which, involving as this does paralysis of volition, permits an excessive and irregular display of emotion in one of the various forms it assumes. This view, which transfers the seat of the mischief from the emotions themselves to volitional or inhibitory power, might suggest the more accurate term of *Inhibitory Insanity*, but I think the opponents of *Moral Insanity* would still object that no delusion or weakness of intellect was present to justify the idea of insanity in its legal sense.

I would at once say that I consider the question can be approached only on the lines opened out to us by Laycock in regard to the reflex action of the brain itself; by Monro in regard to the negative and positive states of this organ present at the same moment; by Anstie, who so clearly showed the true nature of alcoholic excitement; and by Herbert Spencer and Dr. Jackson, who, in their respective spheres of thought, have so greatly elucidated psychology, and the pathology of nervous diseases.

It is, in the first place, clear that in those cases in which passion and impulse predominate, there is no proof that there is any disease of the lower or automatic functions of the brain. It suffices to hold that the highest level of evolution—that which Jackson terms provisionally "the most voluntary"—is affected, and that here we witness only the unchecked action of the lower level, consequent upon the dissolution of the higher. Thus the positive symptoms which we witness are themselves healthy; they are only out of proportion. Certain cerebral areas which are in a negative condition are the real seats of disease. If in consequence of the driver of a coach being drunk, or asleep, the horses run away, it is obvious that they are healthy enough; the cause of their running away rests with the man who is no longer able to hold the reins.

There are other forms of moral insanity which do not so much suggest that the passions have been freed from con-

trol in consequence of the "most voluntary" centres becoming functionless, as that the higher levels of evolution with which the altruistic sentiments are associated have become the seat of such morbid changes as cause their inaction.

With regard to the class of cases in which the character has always been morally sub-normal, the highest level of evolution reached is a low one; the controlling power is weak, and the altruistic sentiments are feebly developed.

That Epilepsy should so frequently be associated with Moral Insanity, both in its impulsive and egoistic forms, accords with what we should expect from a consideration of the fact that there is an exhaustion of the higher centres with which are associated the most voluntary acts and the altruistic sentiments.

The same observation may be made in reference to dipsomaniacs; and as regards Anstie's explanation of the effects of alcohol, I would say that the keynote to his observations is contained in a single sentence, in which he says that "mental excitement implies cerebral paralysis, and is no proof of stimulation. . . . Violent outbreak of the passions is due, not to any stimulation of them, but to the removal of the check ordinarily imposed by reason and will." ("Stimulants and Narcotics," p. 78, 1864.)

There are, indeed, cases of moral insanity in which I think it may be doubted whether the sequence of events is that now referred to as proceeding from above downwards. Thus if a man in consequence of the presence of worms in the rectum is seized, as has happened, with uncontrollable sexual impulses, which pass away when the cause is removed, peripheral irritation sets up reflex action of the brain so powerfully that the highest voluntary centres are unable to control it. Here the order of events is clearly not such as I have been insisting upon. The same remark would apply to the disturbances and excitement of sexual passion which occur at puberty. It is not that any change has taken place in the first instance in the highest evolutionary centres; they are secondarily incompetent from the increased activity and force of lower centres.

There are cases, I would say, which may be aptly described as examples of *immoral resolution*, while others are more correctly designated as cases of *moral irresolution*. The latter occur in men of feeble organization, or of mental constitution originally robust, but enfeebled by disease; they are, so to speak, negatively immoral. The former constitute a class with abnormally strong impulses, natural or acquired,

the result of disease or congenital malformation. They are the positively immoral.

One word may be said here arising out of the fact that one of the earliest symptoms of insanity, whatever course it may ultimately run, is the change which takes place in the feelings. This is so striking a fact, that some* have, as we know, held that all insanity originates in disordered emotion. It has been no less truly than aptly said by a French alienist (Lélut), that at the beginning, insanity is still reason, as reason is in countless instances already madness. Insanity is still reason, because Volition and not Thought is affected. If the emotional genesis of insanity be true, what follows? Why, that there is a stage in the progress of the disease in which it has not yet invaded the domain of what are generally designated the intellectual faculties. What if a crime is committed when a patient is in this early stage of the disorder? Is he not to that extent the subject of emotional or moral insanity? Is the fact altered because in a few more months distinct delusions or decided loss of memory succeeds to emotional disturbance?

I think that the occurrence of moral insanity or moral imbecility might be predicted from a consideration of mental evolution and moral development from one stage or level to another. To one difficulty in the acceptance of moral insanity, pure and simple, I shall refer later on. But putting that aside for the moment, one would expect that the development of the individual might stop short of the highest—the altruistic—sentiments, while only the egoistic (or at most the ego-altruistic) feelings may be in healthy activity. We must remember that what is in startling contrast with modern civilized society may represent the normal tide-mark of a former barbarism.† That some should at birth revert to the condition of a prior ancestry and that moral im-

* Dr. Bucknill propounded the emotional theory of Insanity, and that "intellectual disturbance is always secondary," in the "Medico-Chirurgical Review," Oct., 1853, and Jan., 1854, and the "Journal of Mental Science," Oct., 1874, and consistently with this view, stated that "all medical men of experience now acknowledge the occasional existence of mental disease, without disorder of the intellectual faculties." The non-occurrence of intellectual disturbance in Prichard's cases is attributed to "the unusual force of a conservative tendency in the intellectual faculties." ("Journal of Mental Science," Oct., 1874, p. 486.)

† "The ego-altruistic sentiments may develop to a great height, while the altruistic remain comparatively undeveloped. For under past conditions of social existence, the welfare of society, and of each individual, have not necessitated any repression of the ego-altruistic feelings; but contrari-wise, the pleasure of the individual and the well-being of society have both demanded the growth of this feeling." ("Principles of Psychology," Vol. ii., p. 611.)

becility should appear, is surely consistent with all modern teaching on heredity. In others, again, who possess normal constitutions at birth, it may well happen that disease will destroy the activity of those sentiments which have been more recently evolved, while the lower centres are left intact.

But I grant that an apparent difficulty presents itself in treating the question of moral insanity from the standpoint of evolution. It is this: If intellect or thought is of later growth than feeling, and if, as evolutionists suppose, the most recently evolved—the least organised therefore—is the first to go, how is it possible that Feeling can be disordered without the Intellect being involved? In other words, how can the deeper down Feeling go before the higher up Intellect? As Dr. Savage, in the paper referred to, does not take notice of this evolutionary difficulty, I conclude he does not recognise it, or holds that a speculative difficulty of this kind does not destroy the force of clinical facts.

This difficulty has clearly no force in those instances to which I have just referred, in which reflex cerebral action is induced by distal irritation. The difficulty occurs when we regard the lower mental levels coming into force, and, in fact, forming the then existing character of the individual, and the higher levels of mind as being either undeveloped or rendered powerless by disease. It must be remembered, however, that while simple Feeling lies deeper than Thought, the highest feelings of all—the altruistic—are of later growth; and are quite as recently organised, to say the least, as the faculty of reason or cognitions in general. It seems also very credible that the more voluntary centres may be undeveloped or suspended, while what are usually understood as the intellectual powers may be unaffected.

Having regard to man's past history, it cannot be said that when his moral development was retarded by his predatory or other egoistic pursuits he was an imbecile; and if not, why should there be any difficulty in crediting a sporadic reversion to a parallel condition in the midst of a moral and refined state of society?

It is worthy of note that while the more voluntary power may be lamentably weak, those intellectual faculties which remain in force are of a very automatic character. Musical ability is a striking illustration. We all know that Handel, Beethoven, and especially Mozart, felt their wonderful powers to be so extremely automatic that they attributed them to inspiration. With painters there has been the same feeling,

as with Claude of Lorraine, said to be a stupid boy; and even Raphael, who so far from taking credit to himself for his marvellous facility with the brush, said that a spirit, which he believed to be that of his deceased mother, inspired his imagination with forms of beauty which he had only to copy.

I once asked Herbert Spencer how he would reply to a lawyer opposing the doctrine of Moral Insanity on the ground that as Intellect is held to be evolved out of Feeling, and as Cognitions and Feelings are declared by him (Spencer) to be inseparable, there cannot be organic or acquired *moral* defect without the *intellect* being involved. Spencer's reply contains nothing which militates against what I have said. On the contrary, he finds* an indication of such structural deficiency as may lead to results alleged to be present in moral imbecility (and insanity) in the following position. Every complex aggregation of mental states is the result of the consolidation of simpler aggregations already established. This higher feeling is merely the centre of co-ordination through which the less complex aggregations are brought into proper relation. The brain evolves under the co-ordinating plexus, which is in the ascendancy, an aggregate of feelings which necessarily vary with the relative proportions of its component parts. But in this evolution it is obviously possible that this centre of co-ordination may never be developed; what Spencer calls the higher feeling, or most complex aggregation of all, may never be reached in the progress of evolution, and moral imbecility may be the result, or such waywardness of moral conduct from youth upwards as it is maintained occurs without marked disorder of the intellect.

Again, in the absence of congenital defect, where the moral character changes for the worse under conditions which imply disease instead of mere vice, Spencer finds a clue to a probable cause in so simple an occurrence as fretfulness, which arises, as we all know, under physical conditions, such as inaction of the alimentary canal. Fretfulness is, as he justly says, "a display of the lower impulses uncontrolled by the higher." This is essentially a moral insanity. So is the irascibility of persons in whom the blood is poor, and the heart fails to send it with sufficient force to the brain. Spencer puts it in terms which bear directly upon

* See the same views expressed in the "Principles of Psychology," Vol. i., p. 575.

the question we are discussing when he says, "Irascibility implies a relative inactivity of the *superior* feelings. . . . The plexuses which co-ordinate the defensive and destructive activities, and in which are seated the accompanying feelings of antagonism and anger, are inherited from all antecedent races of creatures, and are therefore well organized—so well organized that the child in arms shows them in action. But the plexuses which, by connecting and co-ordinating a variety of external requirements, have been but recently evolved, so that, besides being extensive and intricate, they are formed of much less permeable channels. Hence, when the nervous system is not fully charged, these latest and highest structures are the first to fail. Instead of being instant to act, their actions, if appreciable at all, come too late to *check the actions* of the subordinate structures."* We see, then, that with Spencer there is no real paradox in holding that cognitions and Feelings are at once "antithetical and inseparable," and that while "no emotion can be *absolutely* free from cognition" (p. 475), it is not impossible that there should be varying degrees of relative development of emotion and cognition; and such "a relative inactivity of the superior feelings," to use his own words, that what is understood as "moral insanity," for want of a better term, is the natural outcome of mental evolution and dissolution.

It is a striking proof of the essential uniformity of human nature in its morbid developments, that we find the questions we are now discussing with so much interest no less the subject of debate in the days of Horace. The third Satire of the second Book is a most remarkable one from this point of view, and would of itself form an excellent text for a discourse on Moral Insanity. Stertinius is the speaker :—

Mad shall the man be counted, who
 Confounds, on passion's impulse, true
 With false, and doing what he thinks
 Most just, to deeds of vileness sinks ?

* * * * *

Well ! if a man shall doom his daughter
 Instead of a dumb lamb, to slaughter,
 Shall he for sane be reckon'd ? Never !
 In short it comes to this,—Wherever,
 Whenever, sin and folly meet,
 There madness is, supreme, complete.

Lastly, I would say that the Great Temple of the ancient Aztecs, in one part of which the officiating priest plunged

* "Principles of Psychology," Vol i., p. 605.

his knife into the breasts of women and children, while in another the priests were engaged in tending the sick, does not present a greater contrast, or a more amazing contradiction, than the union in the same mind of an acute intelligence and uninhibited passions.

Briefly, then, I would summarise what seem to me the conclusions warranted by what I have brought forward:—

1. The cases recorded in the “Journal of Mental Science,” along with those I have mentioned in this paper, afford examples of a morbid cerebral condition in which the mental symptoms displayed are the emotional and the most automatic rather than those concerned in cognition, and may be referred to the form of mental derangement usually called Moral Insanity, although the moral sentiments may themselves be free from disease.

2. There are several varieties of this form of insanity, but that, speaking generally, the higher levels of cerebral development which are concerned in the exercise of moral control, *i.e.*, “the most voluntary” of Jackson, and also “the altruistic sentiments” of Spencer, are either imperfectly evolved from birth, or having been evolved, have become diseased and more or less functionless, although the intellectual functions (some of which may be supposed to lie much on the same level) are not seriously affected; the result being that the patient’s mind presents the lower level of evolution in which the emotional and automatic have fuller play than is normal.*

* Nearly forty years ago the fellow-townsmen of Prichard, the accomplished Dr. Symonds, wrote as follows:—“It seems to me strange when we reflect on the large share which the emotions and sentiments and passions bear in the mental constitution of man, and when we consider that there has been no disinclination to attribute susceptibility of separate and independent derangement to another part of our constitution, I mean the purely intellectual; and, moreover, that the most strenuous asserters of the doctrine, that insanity, in all cases, involves a perversion of judgment, do not attempt to conceal that the propensities, tastes, and emotions are often, or indeed in most cases, morbidly affected; I say it seems strange that the question should not have presented itself before as to whether there are not actual cases in which mental derangement is confined to the moral feelings and the emotions, just as in other cases the perceptive and reasoning powers are the sole subjects of disorder; and stranger still, that, whether such *a priori* suspicions ever arose or not, the real existence of such cases should not have attracted observation. That they have been so entirely overlooked can only be explained on the ground that the sentiments and passions of man have been generally considered subservient to the will and reason, and that any undue excitement of the former (the passions) has been consequently supposed to arise either from a criminal want of control on the part of the will, or from a deficiency of rational power; so that, according to this view, a man of violent passions or eccentric conduct, unless proved to

3 No absolute rule can be laid down by which to differentiate moral insanity from moral depravity, but each case must be decided in relation to the individual himself, his antecedents, education, surroundings, and social status, the nature of certain acts and the mode in which they are performed, along with other circumstances fairly raising the suspicion that they are not under his control. In no other form of insanity is it so necessary to study the individual—his natural character, his organization and his previous diseases.*

The Necessity for Hospital Treatment for Curable Cases of Insanity. By S. A. K. STRAHAN, M.D., Assistant Medical Officer, Northampton County Asylum.

Dr. D. Hack Tuke in his interesting work, "Chapters in the History of the Insane in the British Isles," has shown how the asylum of to-day was evolved from the madhouse of old. Originally the madhouse was simply a prison in which persons who had shown themselves dangerous to their fellows because of madness were confined and punished. With the general advancement of knowledge and civilization, the lamentable lot of the madman improved. One barbarous and inhuman custom after another was dropped, and at length it was dimly recognised that madness was a disease. Then for the lunatic the day of salvation was at hand—the cell, the chains, and the whip became things of the past, and he stood emancipated from all but his terrible disease.

Since then great strides have been taken in the direction of ameliorating the condition of the insane, and thereby improving their chances of recovery; but who will say that the study of the causes and treatment of insanity has kept pace with that of other human ills? With the aid of all the appliances of modern science, medicine and surgery step on apace—the turbid stream of disease is being followed through a hitherto unknown land, nearer and nearer to her sullied source; yet what is there in psychological medicine to correspond with this general advance? With all the

entertain some delusion or hallucination, must be either wilfully perverse or chargeable with moral delinquency."—"Miscellanies of John Addington Symonds, M.D.," p. 136.

* For the discussion on this paper see "Notes and News." [Eds.]

great opportunities offered for study and research in our large asylums, the alienist is only moving at a snail's pace as compared with the onward march of the surgeon and general physician.

Well-meaning men of both the legal and medical professions, and many of their representative journals, frequently say hard things of the mad doctor, things which hurt none the less because they are partly true. We are inclined to look upon these remarks as being conceived in a spirit of ill-feeling and unfriendliness; yet to the unprejudiced mind there is much to be said in their support. The great mistake made is that the *individual* is attacked and abused, while it is the *system* alone that is at fault. Dr. Van Bibber, in a recent number of the "American Journal of Medical Sciences," has, in a clear and conclusive manner, pointed out where the error lies. He shows that our large asylums are not really places for the treatment of the insane, but only for their *care*. The asylum of to-day does not belie its name; it is, in truth, a sanctuary, a refuge, an asylum for the mentally afflicted, and in most cases it is nothing more. So long as we continue our present mode of procedure, and send our curable cases of mental disorder and disease to herd with hundreds of chronic maniacs, demented, and gibbering imbeciles, so long shall we continue to increase our insane population, and so long will psychological medicine remain on a back seat in the councils of the sciences.

The county and borough asylums as at present established and managed in England are admirable places for the care of the hopelessly incurable insane, but we must admit, however unpalatable may be the admission, that they are not, nor can they easily be made, hospitals for the treatment of disease. It is, as has been pointed out again and again, simply impossible that a man can perform the thousand and one duties devolving upon the Superintendent of a large institution and at the same time give to recent and curable cases under his care that attention and thought which they require. As Dr. Van Bibber says, "The Superintendent of a large asylum does not long remain a doctor after he has assumed his duties. All his efforts to treat insanity soon dwindle into some administrative hobby, and the best intentions for the advance of medical science become inevitably developed into ideas of economy and management. He is now a manager. The mainspring of every asylum is how

much per week?" How true is this. It is a fair and honest statement of the case. The Superintendent must become a manager or cease to be a Superintendent, and when he becomes a manager he ceases to be a physician.

Again, I think it must be admitted that, even if curable cases of mental disorder could there have all the requisite medical attention, a large asylum filled with chronic lunatics is hardly the best place for treatment. That repose and absolute quiet so often a *sine quâ non* in the treatment of such disorders are not to be expected in such a place, while the nurses and attendants, too often ignorant of the very rudiments of the art of nursing, can hardly be looked upon as ministering angels.

In saying this I do not mean to reflect upon this very deserving class. With very few exceptions I have always found them kind and long-suffering, and, according to their light, considerate and humane. But as we do not expect to gather grapes from thorns or figs from thistles, we cannot expect the erudite touch which so aids the physician from the hand that has just dropped the broom or the spade, nor the quiet of the sick chamber in the midst of chronic lunatics.

Now how are we to remedy this state of affairs? All that is said above being for the moment taken as proved—it is generally admitted—the question is, how best can we remedy these evils? The answer to this question must be, I think, "by the establishment of the long talked of intermediate hospital."

It has been proved that, even in the few and far too large hospitals we already have, the recovery rate is much higher than in the county and borough asylums. In these hospitals an attempt is made to treat the patients individually, and we have the result of this in a considerably increased recovery rate.

The difficulty of course is to adapt the hospital system of treatment to the pauper lunatic. This could most easily be done by the establishment of a small hospital in connexion with each asylum. This hospital would be in the asylum system, but not of it. It should be a detached building for 30 or more beds as the population of the district required. It would have a physician whose sole duty it would be to attend to his patients. There would be a nursing staff who would carry out the medical orders to the letter, as in any other hospital. The superintendent of the neighbouring

asylum would act as manager of this hospital, but appear in the capacity of medical man only when desired by the hospital physician. All cases deemed curable would be received into this hospital—idiots, imbeciles, and hopeless senile and chronic cases going direct to the asylum. Cases not recovering, or showing signs of probable recovery within a reasonable time, would be transferred to the care of the asylum authorities to make room for fresh cases.

A small hospital of this kind, built on the generally ample grounds of our present asylums, would not cost much, and would soon become a source of profit to the ratepayers; prevent to a great extent the now ever-recurring necessity of enlarging asylums—in fact, tend to keep the insane population within reasonable limits.

Here the physician would be a physician in reality as well as in name. It would be his life's work to treat his patients and study their diseases. He would not have many and grave business matters constantly weighing on his mind. He would not profit by a low rate per week, nor suffer through a high one. He would be a physician pure and simple, whose sole interest would be the recovery of his patients.

There are difficulties in the way of the establishment of hospitals like that sketched above, but these difficulties are not great; they are difficulties which must and will soon be overcome. The day of hospital treatment of the insane is fast approaching, and until that day arrives psychological medicine must remain in its present backward state, and the asylum superintendent receive the opprobrium which the system and not the man deserves.

A Glance at Lunacy in Spain. By F. A. JELLY, M.B.,
Assistant Medical Officer, Wonford House Asylum,
Exeter.

While on a short visit to Madrid some little time ago I determined to find out how Spain treated her lunatics. I visited the public asylum of Santa Isabel at Leganes, but was refused admission, as there was no resident physician, and the village doctor, who was supposed to make his rounds at 9 a.m., was away! A friend, however, kindly gave me an introduction to the leading Spanish alienist, Dr. D. José Esquerdo, who, he told me, had a private asylum at Carabanchel, and thither I went. This little village is about three miles from Madrid, and easily reached by tramcar.

Dr. Esquerdo's asylum stands on an elevated, sandy plain, about 200 mètres from C. Alto, and is approached by a steep, rugged road. In external appearance it is most unlike our ideas of a private asylum: not a tree to be seen for miles, and the whole block of buildings is enclosed by wooden palisades.

On passing through a gate I came into an attempt at a garden, consisting of a few stunted shrubs striving for existence in a wilderness of sand and rubbish. After ringing several times at a primitive bell suspended near a door, and being gazed at through an adjacent barred window, I was admitted into a small unfurnished vestibule, where I caught sight of statuettes of Pinel, Esquirol, and one or two other alienists. I was then led into a large reception-room, painfully Spanish in its dirt and bareness, somewhat relieved, however, by a few well-known coloured illustrations from the "Graphic." I was shortly joined by a gentleman, who regretted that his uncle, Dr. José Esquerdo, was not at home, but he was his nephew and senior resident, and would be most happy to take me round and answer any questions. I should here like to bear my testimony to the frank kindness and hospitality of Dr. Santiago Esquerdo, as these qualities are very rare among Spaniards. On my stating that I wished to see the ordinary management of the place, he invited me at once to join himself and the male patients at their midday meal, and, taking me through a dark room in which were a few invalids eating, he ushered me with much Spanish formality into a fine marble-floored dining-hall that would put many Continental hotel dining-rooms to the blush. Light came in through stained glass windows, and at the further end was a high dais separated from the rest of the hall by balustrades. The majority of the patients sat at two tables placed in the centre of the room, and presided over by the junior resident and the dispenser, each of whom, by the way, like Dr. Santiago, wore a sort of grey uniform and a peak cap with gold band round it. We sat at a table, placed transversely on the dais, with about eight of the better patients, so that everyone was under the eye of the senior medical man. A very good Spanish meal was served, the well-known puchero forming the principal item of the *menu*. The patients, though very untidy and forbidding, for the most part behaved admirably. Spaniards are not, when sane, very cleanly eaters, and I will not attempt to describe the various methods of disposing of their food

adopted by these poor lunatics. They appeared to enjoy the meal, and after the usual figs and raisins many of them lit cigarettes, while Dr. Santiago and I adjourned to his sanctum, a small room into which no light or air could be admitted without opening a large door which led on to the high road! Such, however, are many of the rooms, even in the largest towns of Spain, only one certainly expected something better in a large private asylum. We had a very agreeable chat, however, over our coffee, Dr. Santiago showing me, with pride, about half-a-dozen books on mental diseases, all French except one, which was a Spanish translation of one of Dr. Maudsley's works. The Spaniards are not a literary people, and indeed it is marvellous how they obtain any knowledge of scientific progress at all, as one never comes upon a man reading anything but a newspaper. On enquiring as to the rules of admission to the asylum I was shown some manuscript papers, and it was explained that a letter of application from the friends or relatives was required, and one medical certificate. The rest of the paper was supposed to be filled with the history of the case, but, as he said, "I am a little behindhand with my work;" and indeed there only appeared one sheet anything like filled up! The patients are divided into three classes, according to the fees paid, the first paying at the rate of £240 per annum, the second £144, and the third £72. The distinctions as to accommodation and food are most clearly given in the small prospectus, the first class, among other privileges, being permitted to go out twice a week in the carriage.

The Asylum has now been in existence for five or six years, and contained 88 males and 33 female patients; great additions were being made to it, so that I did not see it at advantage. Dr. José Esquerdo, when in residence, occupies the central block of buildings, which is surmounted by a tower fitted with glass all round, and "here," said Dr. Santiago, in most flowery Spanish, as we gazed on the exterior, "Dr. Esquerdo sits continually to watch the patients and to give to the world those observations which are calculated to shed a brilliant light on the obscure treatment of mental disease." I could only bow and inwardly regret that a few rays of the brilliant light had not shone over England!

From this central block extend the male department on one side and the female block and chapel on the other, the whole forming three sides of a square. Each block is two stories high. The room I had been shown into at the first

proved to be the general sitting-room for the gentlemen, and here I came upon a fine-looking Englishman, who had almost forgotten his native language, suffering from general paralysis. According to Dr. Santiago, there were about eleven males suffering from that disease in the asylum, and one female.

On the same floor were two padded rooms, the small windows of which were filled in with glass, tinted-orange and blue respectively; but after a close study of the effects of coloured glass on the patients, their results were *nil*. Adjoining these rooms was a small, dingy recreation-room, but I observed a large billiard and reading-room in process of building. The bedrooms, for the most part, were upstairs, one attendant sleeping at either end of the gallery, except in the case of patients of the first class, who had an attendant sleeping in a windowless den off their bedroom.

The female side differed little from the male, except, I think, it was dirtier, and the patients looked more miserable, except one lady, a kleptomaniac, who was seated like a Queen in the midst of an accumulation of well-sorted rubbish.

There were about four patients under restraint, and I mention this because the methods adopted were most primitive, and, I may say, inhuman. One poor fellow, I remember, had three broad straps buckled round himself and the bed, besides huge ropes knotted and twisted round him in the most hideous manner, being effectually prevented from moving a single joint. Dr. Santiago told me they did not believe much in drug treatment; and I gathered that the dispenser had an easy time of it.

Mass is performed daily in the little chapel, but as attendance is not compulsory, few are orthodox. There were no out-door amusements provided for the patients, but I understood that a wall was soon to be erected for the Spanish *Juego á Pelota*, a game resembling our "fives."

I may state, also, that Dr. Esquerdo has a country house, called "The Paradise," at Villajoyosa, about five leagues from Alicante, and several patients are taken down there every summer.

I have now tried to give a glimpse of the arrangement of a private asylum in Spain; and though, as I have hinted, there was much that grated on our ordinary ideas of cleanliness, order, and the treatment of the patients, still we must remember that the patients and staff were Spaniards, and I think it is a hopeful sign that such a place exists in such a country. I regret greatly that I was unable, during my

short visit to Spain, to see through a public asylum; but during other interviews with Dr. S. Esquerdo, and also with his courteous uncle, I gathered a little further information that I think may be of interest.

The Spanish alienists boast that the first asylum in the world was erected in Spain, in the year 1408, and a monk, Fray Jofre Gilbert, gets the credit of having awoke the nation to a sense of the importance of caring for the hitherto neglected insane; so that during the fifteenth century four asylums were erected in various parts of the Peninsula. Now about thirty exist, the most celebrated being that of Nueva-Belen, near Barcelona. The superintendent of this Institution is Dr. D. Juan Giné y Partagas, the writer of the only original work on insanity in the Spanish language, from which I have taken the following classification of mental diseases, which is said to resemble that of Guislain, but which seems to me to be one of the most unintelligible that has ever been drawn up:—

1. *Melancholia*, defined as pathological emotion of sadness or moral grief, consisting in depression, uneasiness, fear or terror.

2. *Ecstasy*, defined as suspension of the functions of sensibility, mobility and intelligence, the patients appearing as statues.

3. *Mania*.—Pathological emotion, with exaltation of one or more functions of the mind, characterized by a state of agitation, exaggeration, together with exaltation and agitation of the hostile passions.

4. *Locura or Madness*.—An emotional state, in which the patient finds himself irresistibly impelled by a whimsical will to commit acts which do not bear in themselves the characters of an active passion. It is a monomania of action without raving ideas!

5. *Delirium*.—Notable aberration of the intellect; error of judgment and disquietude of the ideas in a chronic form.

6. *Dementia*.—Weakness or more or less complete obliteration of the moral and intellectual faculties, frequently accompanied with lesions of mobility!

These six primary divisions, with the exception of ecstasy, are split up into various minor ones, particularly mania and locura, which have 17 and 16 sub-divisions respectively. Some of these, such as “ambitious mania,” “mania of vanity,” “barking madness” and “mewing madness,” seem somewhat superfluous.

I may just state, in conclusion, that there exists an Association, termed the Spanish Frenopathic Academy, which resembles somewhat our Medico-Psychological Association, only the former contains very few members.

I fear this glance at Lunacy in Spain is presented in a very imperfect and disconnected manner, but if it stimulate any of the members of this department, while taking a holiday amid the historic cities of Spain, to visit and so encourage the Spanish alienists, I think they will certainly not regret the time so spent; and, at any rate, in Madrid, I can assure them of a hearty welcome from Dr. D. José Manuel Esquerdo.

CLINICAL NOTES AND CASES.

A Case of Imbecility with Well-marked Hereditary History.

By FLETCHER BEACH, M.B., M.R.C.P., Medical Superintendent Darenth Asylum.

Hereditary predisposition is well known to play an important part in the production of imbecility, and as this predisposition can be traced through four generations in the following case, I have thought it worthy of being placed on record:—

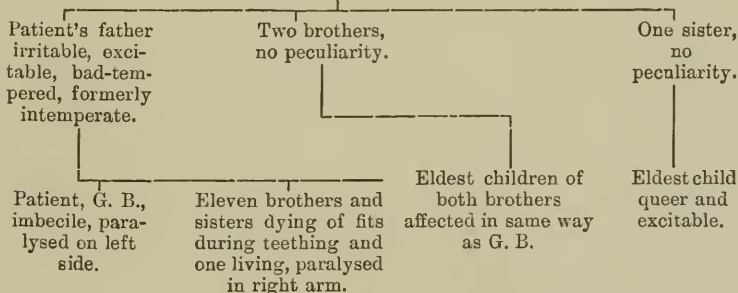
G. B., aged 15, was admitted into the Clapton Asylum on May 12th, 1875, with the following history:—The patient's great-grandfather was "not bright." The grandfather was very reserved, and the grandmother excitable and queer. The father of the patient was irritable, excitable, bad-tempered, and formerly intemperate. The eldest children of two brothers of the father are affected in their intellect in the same way as the patient, and the eldest daughter of the father's sister is queer and excitable. The patient, G. B., was born paralysed on the left side, and is excitable at times. When three weeks old he had a fit, and the fits continued until he was 11 years old. He was an imbecile who made little progress in school in consequence of his paralysis and difficulty of speech, but did fairly well in the shoemaker's shop. Eleven of his brothers and sisters died of convulsions during teething, and one was paralysed in the right arm.

In the first generation, then, we have weak-mindedness; in the second a peculiarity of temperament which caused the patient's grandfather to be "very reserved." As a result of his marriage with a person who is "excitable and

queer," there result in the third generation the patient's father, who is "irritable, excitable, bad-tempered, and at one time intemperate," and finally, in the fourth generation, the patient, G. B., who was imbecile from birth, 11 brothers and sisters who died of convulsions, and one who is paralysed in the right arm. The insane neurosis does not affect alone the direct line, however, for as a result of the union in the second generation of a man who is "very reserved" with a woman who is "excitable and queer" there result two sons, whose eldest children are affected in the same way as the patient, and one daughter whose eldest child is "queer and excitable." These facts will come out more clearly in the accompanying genealogical table:—

Patient's great-grandfather not bright.

Patient's grandfather very reserved = Patient's grandmother excitable and queer.



It can scarcely be questioned that we have the insane neurosis running through the family from the great-grandfather down to the patient. Passing by the great-grandfather, who was "not bright," the grandfather's very reserved disposition cannot be considered a normal one, and much resembles the man of insane temperament who lives a life of solitude, preferring to have little to do with his fellow-creatures. By the grandfather's marriage with an excitable and queer wife the evil is intensified, witness the nervous instability of the patient's father, the imbecility of the patient, and the mode of death of his brothers and sisters. The side groups are also affected, for although the uncles and aunt of the patient present no peculiarity, yet the insane temperament evidently runs through them, producing in the one case imbecility, in the other excitability and queerness in the children.

If anyone questions my opinion that irritability, queer-ness, and excitability are signs of the insane temperament, I would say I am upheld by Dr. Maudsley, who, when speaking of this temperament, says*: "The person is prone under all circumstances to strange or whimsical cranks of thought and caprices of feeling, or to eccentric or extravagant acts, and likely under the pressure of extraordinary circumstances to suffer an entire overthrow of his mental equilibrium: there is, as it were, a loss of the power of self-control in the nerve-centres, an incapacity for calm, self-contained activity, and energy is dissipated in explosive discharge, which surely denotes an irritable weakness."

Two Examples of the Effect of Removal of Higher Power of Self-Control: one due to Chronic Insanity with Recurrent Outbreaks; the second due to the Inhalation of Chloroform.
By Dr. SAVAGE.

Mary W., admitted in 1871, and removed to the incurable establishment in 1876. She is now 75 years old. Has been subject to partial weak-mindedness with recurrences of acute mania ever since the first attack. She is a quiet industrious person, always contented and intelligent, with the most perfect self-command, and never given to the use of strong or bad language. Her attacks of acute insanity are quite irregular in their recurrence, and without known cause, physical or mental.

The last attack began in the autumn of 1884, and was, as usual, marked by violent language and destructive habits; the patient at the same time becoming thin and ill.

The excitement continued till early in 1885, when she became managable, and wished to be tried in a more quiet gallery. This wish of hers was satisfied, but she was unable to control herself, and had to be sent to the refractory gallery again.

Physical improvement took place, but little mental gain was noted. A second time she was sent to a quiet gallery, but this time only for the day, as at night she was very noisy and abusive.

Her custom at present is to go quietly to bed, sleep for some hours, and in the early hours of the morning to wake, and begin abusing everyone connected with the place. Her language is very bad. This lasts for some two hours, or

* "Pathology of Mind."

even more; she has her bath and breakfast, and remains quiet, and, to a certain degree penitent till the next morning. She says she cannot help it, though she knows it is wrong. Thus we see that in the early morning when gout comes on, and when melancholia is most marked, she loses her self-control and swears like a trooper.

CASE II. is that of H, who was for some time in South Africa. Is single, 26; said to have been fairly sober, whatever that may be at the Cape. For some time before insanity was suspected, he was restless, and unable to follow his occupation. He is said to have had "brain fever" at school, but has been able enough ever since. He at first became sleepless, then steadily passed into a state of the most violent mania. He had to be kept for some time in seclusion, and even in a padded room managed to smash a shuttered window and damage his right thumb. As a result of the injury, common inflammation set in, and he had several very deep abscesses among the muscles; these were opened from time to time.

When his hand was at its worst his mind cleared and he was most polite and gentle. While so gentle it was thought well to give him a small dose of chloroform so as to be able to examine his thumb more fully. No sooner was he under chloroform than at once he passed into the same state in which he had been while maniacal, so that he made use of the very same words and was impressed with the same ideas—*i.e.* that Gordon was in some way connected with him. The repetition of his former maniacal state was exact, and was lost on his recovery from the chloroform. When, later, a fresh attack of excitement followed, he had a small dose of hyoscyamine, and then he became, after the effects of the drug had passed, in very much the same state of violent excitement. Thus in this case a man recovering from mania was thrown back into his old state by the use of chloroform, and a similar but more persistent revival of delusion followed the use of hyoscyamine.

Case of Marked Hysteria in a Boy of Eleven Years. By Dr. SAVAGE.

Charles L., aged 11. No insanity in the family; has been healthy and intelligent; had scarlet fever as an infant. He was in every way healthy till January 4, 1885, when he went to the funeral of a little sister who died as the result of an accident. On January 5 he did not play, and gave up all

his ordinary habits: became dull, his appetite failed, and his bowels became confined. He evidently had some delusion about his motions, for he said he did not pass anything; but it was found out that he threw one motion out of the window. He would refuse to eat with the rest of the family, but would steal food or eat it on the sly.

During February he was in much the same condition, except that he would hide his face and scream for hours together. The next month was marked by a further development of the symptoms, so that he said he could not walk. He would be on his pony during the morning, return to the mid-day meal, then about two, would cover up his face with a handkerchief and begin to shriek and yell till he fell asleep. During all this time he would have his feet drawn up under him. He did not lose flesh, but remained plump and ruddy.

On admission, on April 23, he was crouched into a ball, his face tied up in a handkerchief, and both his legs drawn up under his buttocks, and both his feet turned inwards, so that he stood—when forced to stand—on his outer malleoli.

He said, when questioned, that he had pain in his head, at the vertex. He still said he did not have motions, and hid or threw away his stools.

There were no signs of any bodily illness. He was very noisy for the first day, and we considered the case one of a hysterical nature.

He was ordered judicious neglect, and shower baths.

There have been no more screaming fits.

There is no evidence of any sexual vice, and being carefully watched, he is apparently free from any evil practice.

Daily he is induced to play with a racket bat, and also to pick up the tennis balls. He has regular daily exercise with one of the parlour gymnastic apparatus, and also is taken once daily by an attendant for a plunge-bath and swim. He is gaining power over his lower extremities, or rather, he is losing the habit of walking on his external malleoli, and will soon recover.

Many will say, Why send such a case to an asylum? and I must say I accepted him with hesitation, and only after being convinced that his friends could not manage him, and that he was steadily going from bad to worse. I have seen several cases of marked moral perversion younger than this, but never before have I seen so good a case of great emotional disturbance associated with some moral defects so distinctly connected with a shock.

Case of Profound and somewhat Prolonged Suicidal Melancholia ; Diarrhœa with Fever ; Recovery. By Dr. CARLYLE JOHNSTONE, Assistant-Physician at the Morningside Asylum, Edinburgh.

Admitted into the Southern Counties Asylum 3rd January, 1883. Female. Single ; 40 years of age. Domestic servant. First attack. Insane probably for several weeks. Cause unknown ; but it is believed that she had been anxious and worried about her employment. No insanity in the family.

From the statements made by her friends and those contained in the medical certificates, it appears that for several weeks she had been almost without sleep, and that for some days she had been very violent in her behaviour, threatening to commit suicide, requiring forcible restraint, and had taken very little food.

When brought to the asylum she was in a very exhausted condition ; pulse 144 ; tongue foul ; breath offensive. Owing to her refusal of food she was fed on the same day with the stomach-pump. Her mental condition was one of most profound depression ; she was continually moving about restlessly, wringing her hands and exclaiming that she was lost.

After a fortnight's residence, with the use of sedatives and careful nursing, there was considerable improvement in her general health, but her mental condition continued to be one of acute melancholia ; she slept badly ; had made various attempts to injure herself, expressed many delusions, *e.g.*, that "black men" came into her room at night.

Seven months after admission it is noted that she continues in a state of profound melancholia, with marked suicidal and sometimes homicidal tendencies. Has been placed under special observation. Often says that she wants to be killed. On the 8th August she escaped the attendant's observation, and seized a knife, but was prevented from doing herself any injury. On the 10th August she tore a strip from a sheet and attempted to strangle herself, but failed to do herself any harm.

During the next two months she underwent some treatment with the continuous galvanic current. The mental depression was much less profound, but she still expressed the wish that she were dead, and she was extremely irritable, striking anyone who spoke to her without the slightest provocation. At times she stated that she was the "Queen of the three nations." Her general health showed considerable improvement ; she took plenty of food, but was restless at night.

19th November, 1883.—Last night she attempted to commit suicide by tearing down the gas-pipe in her room, breaking the pipe and inhaling the gas. She was discovered before any bad effects had time to develope.

20th December, 1883.—Since last report she has been in a very excited state, frequently asking for knives, scissors, &c., with the

avowed purpose of injuring herself. One day she attempted to strangle herself with a piece of braid which she had torn off her dress. She had now become stout and much improved in her general health, eating ravenously, but still restless at night, and often sleepless. From this period until her removal to the Royal Edinburgh Asylum no change occurred.

On her admission into Morningside Asylum, on 31st January, 1884, her condition was as follows :—

She is a fairly well-nourished, middle-aged woman, with a dull, weary, hopeless look; face discoloured with capillary congestion; hair black, streaked with grey; irides brown; pupils contracted, equal, sluggish; tongue clean; pulse 65, very weak; temperature 97°. There appears to be considerable motor debility; she limps slightly on her left leg; slight flattening of the right side of the face; patellar reflex-action blunted; ordinary and special sensation normal; slight flattening at both pulmonary apices, with rough breathing; cardiac sounds feeble. There appears to be little impairment of the intellectual powers, but there is profound mental depression characterised by a dull apathy and disgust of life. Patient says that she will never be happy in this world, since it is lost to her, and that the only chance for her is to get out of it.

April 30th, 1884.—Patient has the heavy, stupid, degraded look of a hopelessly incurable case. She has no concern in life, save a dull longing to end it. She accosts each passer-by with the request, "Please, will you take my life?" For the rest, she is silent; she denudes herself; tears her clothes into fragments; has filthy practices; is stubborn and intractable; she has a hearty appetite, and gets sufficient sleep, though at times restless at night. On several occasions she has made half-hearted attempts to get into the pond to drown herself.

May 13th.—Nine days ago she had a syncopal attack while walking in the grounds. Afterwards she complained of a feeling of weakness in her left limbs. She was put to bed, and on the following day she was found to be suffering from diarrhœa, with a temperature of 104°. Since then there has been a temperature of about 100° in the morning, and 103° to 104° in the evening; pulse feeble, but of moderate rapidity. There is occasional diarrhœa, with loose, yellow evacuations; tongue at back coated with dirty yellowish fur. There is no eruption, abdominal tenderness, or other indication of enteric fever. Patient lies quietly in bed, making no complaint, takes sufficient nourishment, and when spoken to says drearily, "Please, sir, will you take my life?" She has been put on a simple nourishing diet of fluids, with brandy, opium, and sulphuric acid.

May 24th.—The temperature ranges from normal to 100° in the morning, and is generally considerably higher in the evening, sometimes rising to 104°. Diarrhœa less frequent. No eruption or other grave or suspicious symptoms. Patient appears to be somewhat

clearer intellectually, is much more docile, displays a certain shy gratitude, and seems considerably less gloomy.

June 10th.—The fever and diarrhœa have disappeared. The bowels have been constipated, and yesterday a healthy evacuation was obtained by the use of castor oil. Patient was able to leave her bed to-day. She is still very weak, but has a much healthier look, and is more reasonable and manageable, and less dejected, and but rarely asks to have her life taken.

July 1st.—Since last note she has made steady progress in every respect, and physically, as well as mentally, she is in a much more healthy condition than when she was admitted into the asylum. Her expression is still dull and listless, and she is shy and retiring, but she talks sensibly and pretty cheerfully; is very civil, docile, and grateful, and shows no suicidal tendencies. She sleeps in a general dormitory at night, works diligently during the day, goes out regularly for exercise in the open air, and has a hearty appetite.

August 27th.—Her convalescence progressed in the most satisfactory manner, and she was to-day discharged as recovered, after an asylum residence of nearly one year and eight months.

Five months later she was ascertained to be free from mental or bodily disorder.

Remarks.—This case presents two interesting features. One of these is that the patient should have recovered at all. While it has been seen that the attack of insanity was a somewhat prolonged one (nearly two years altogether), it is not easy to show by a mere description of the case how very bad the prospects of recovery appeared to be. Suffice it to say that of those who had the opportunity of observing and studying its features day by day there were probably none who would have called the case a curable one; and the experience which they thereby gained will probably urge them in future to look with more hope and to spend more pains upon other cases which formerly they would have considered hopeless and unprofitable. A more remarkable feature is the fact of the recovery having taken place after a prolonged attack of diarrhœa, with fever. Whether the diarrhœa may be looked upon as having dispelled the insanity is questionable; the fact is simply recorded.

OCCASIONAL NOTES OF THE QUARTER.

Lunacy Acts Amendment Bill.

To many, especially the proprietors of private asylums, the Lunacy Bill which the Lord Chancellor introduced on March 26th must have proved a great relief. The decree had gone forth *Delenda est Carthago*. The "tradesmen" in Carthage must have congratulated themselves that even a Radical Government had not found in its heart to abolish a "business," in reference to which, the Earl of Milltown made the uncalled-for assertion that "the proprietors of private asylums are as much in business as the proprietor of a theatre or a gin-palace." The Lord Chancellor's Bill has left them alone. He proposes, indeed, to allow county asylums to take in private patients, not merely, as now, to be treated in the same way as other inmates, but to have special provision made for them in the same building, or one erected separately for their use. In this way he hopes to offer to the public the advantages of a private asylum without the stigma now said to attach to the interested proprietor. But we do not for a moment suppose that the friends of opulent patients will avail themselves of this privilege. It is highly improbable also that the County Justices will fall in with this scheme to any considerable extent. And surely the Medical Superintendent of a large County Asylum has already enough to do without this added charge.

It is true that one clause in the Bill, which is just in principle, may tell hardly upon those proprietors of private asylums who receive paupers, unless compensated, inasmuch as at the end of five years, the practice is to cease. Everyone would regret that any class of men in the profession should suffer by the action of legislation for the insane. We believe, however, that the number likely to suffer injury is very small; that the extent of the damage to this limited class would be decidedly less than is feared, and that taking the whole Bill *as amended* into consideration, the gain is so vastly greater than the loss, to the medical profession itself, that it ought not to be allowed to militate against the safety of the Bill.

It is proposed that no private patient shall be admitted into an asylum, or otherwise deprived of liberty, without the order of a County Court Judge, a Stipendiary Magistrate, or

a Justice of the Peace. Although this is guarded by an emergency certificate, and, therefore, delay in admission may be avoided in cases where very prompt action is necessary, we fear that the mere fact of its being necessary to call in a magistrate will sometimes deter the friends of patients from placing them under care in the early stage of the disorder.

It is impossible, however, to deny that in principle it is only right that a man shall not be deprived of his liberty without magisterial authority; and this fact is generally recognised in some form or other in most civilised countries, and already in our own as regards paupers.

It is proposed that the order for a patient's confinement should lapse at the end of three years unless freshly-obtained medical opinion justifies further detention. Whether this is practical or not remains to be seen. In some instances it will create difficulties in families, and tell disadvantageously on the patient.

Again, at the request of any person, two medical men may be authorised by the Commissioners to visit the lunatic in confinement, and if they report in favour of his discharge, they may carry out this decision. The fact is the Commissioners may, under the existing law, discharge any patient of whose detention they disapprove. As the action of the Commissioners upon this petition is permissive, it is doubtful whether they will often act upon the suggestion of outsiders when they can take the initiative themselves; at any rate a great check is put upon the vexatious use of this privilege.

This Bill has been so widely discussed in the medical journals, and has been threshed out so thoroughly by the Parliamentary Committee of the Association, as well as by that of the British Medical Association,* that all that can be now said in regard to its provisions has been said already again and again. It is needful, however, to place on record in this Journal the grounds upon which the major portion of the Association approves of or dissents from these provisions. We consider it desirable also to give a very full abstract of the Bill as amended at the time we write.†

For the first purpose we print a copy of the statement drawn up by the Parliamentary Committee and presented to the Lord Chancellor. In consequence of domestic bereave-

* Subsequently, also, by a Committee of the College of Physicians, appointed on the proposal of Dr. Wilson Fox.

† See "Notes and News"

ment, his lordship was unable to see the deputation from this Committee, but in his absence Mr. Mackenzie, the principal secretary, received the members, headed by the President, and courteously entered into the objections and suggestions made by the deputation.

COPY OF THE ADDRESS OF THE DEPUTATION OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION TO THE CHIEF SECRETARY OF THE LORD CHANCELLOR, 20TH APRIL, 1885.

The Committee of this Association, appointed to consider the proposed Lunacy Law Amendment Bill, desires to express the opinion that the existing Lunacy Laws have, on the whole, worked satisfactorily; and that, although they may require amendment in details, they might, with such alterations, continue to work satisfactorily in the future.

The Committee entertains the hope that, in consideration of the fact that the medical profession has rendered such services to society in regard to the care and treatment of the insane, that no single case of *mala fides* was established before the Committee of the House of Commons in 1877, it may fairly ask, that if the Legislature still imposes on the profession the performance of this same duty, care should be taken not to discredit its members in the eyes of the public or of the patients under their care, by any enactments which imply distrust of their character and reputation.

After a very full and careful consideration of the proposed Bill, we are almost unanimously of opinion that the intervention of the magisterial authority (as provided in Clause 2) prior to the granting of an order for the treatment of a person of unsound mind, is *undesirable*, and will lead, if adopted, to delay in treatment, to attempts at evasion of the law, and other untoward results.

On the other hand, we fully recognize the probability that this proposition for magisterial intervention will pass the Legislature; and, should this occur, greatly as we deprecate such an event, we find it difficult to suggest any officials for carrying out this provision other than those indicated in the Bill, if the powers at present possessed by the Commissioners in Lunacy are deemed insufficient.

We wish specially to direct the attention of the Lord Chancellor to the fact that the justices do not correspond to the officials indicated in the Scotch procedure. The Scotch

Sheriff and Sheriff's substitute, the Steward and Steward's substitute, are barristers of (? 10 years) standing who exercise other judicial functions, corresponding to those of County Court Judges, Recorders, and Stipendiary Magistrates.

The English Magistrates, on the contrary, may have had no judicial experience, and the class of persons appointed in boroughs are often, we fear, not free from social prejudices, which might influence their action in the matters under consideration.

We are also of opinion that it is undesirable that a Magistrate, even a Judge, should be called upon to decide questions of a purely medical character, and still more undesirable that it should be legally practicable for a newly-appointed Magistrate, destitute of judicial experience, to over-rule the scientific opinions of two medical men who might possibly be the most eminent members of their profession.

We believe that such possibilities would early result in great public inconvenience.

We are of opinion, therefore, that the power of these authorities should be purely "ministerial," and that when any doubt on medical questions arises, these officials should not personally visit and examine the alleged lunatic (as provided in the Clause), but only have power to direct a further medical examination.

We beg to suggest that in any postponement or delay of a petition of insanity, the reason thereof should be definitely stated by the acting magisterial authority, by endorsement on the petition, or furnished on demand to the Commissioners in Lunacy.

We are *specially anxious* that some protection should be given to medical persons signing certificates of insanity.

We consider that in furnishing these documents they are not only fulfilling a professional duty, but are also acting by direction of, and to some extent as the agents of, the Legislature.

We suggest that at least they might be shielded from prosecution, both in obtaining and signing certificates, by being held to be the agents of the petitioner for an order of insanity; and that they should be further protected by a provision that no prosecution should be based on such certificates, except with the sanction of the Public Prosecutor.

At the present time, as has been recently illustrated in the case of *Haskar v. Wood and Others*, certificates in perfect form, and a perfectly regular admission to an asylum or lunatic hospital, may be made the basis of a prosecution, ruinous to the medical persons concerned. Unless some protection be given, the existing difficulty of obtaining certificates will be increased; medical men of repute will abstain from giving them; and they will consequently fall into the hands of the least worthy members of the profession. The Bill might be greatly hampered in its operation by an extensive refusal of the profession to accept the risks and penalties which might be incurred.

We strongly recommend the consultations of the medical persons signing certificates (Clause 2, s. 8.), and we suggest that "postponement of a petition" (Clause 2, s. 9) should not interfere with the action of an urgency certificate, should necessity for one arise during the period of the postponement. We further suggest that the provision for secrecy in an examination (under Section 10 of Clause 2) should be more extensive, and should include all persons who become officially acquainted with the facts of the petition, as well as all papers and documents relating thereto.

In regard to certificates required for the confirmation of "urgency orders," we can see no valid reason why one of these should not be signed by the medical person signing the urgency certificate, as obtains in Scotland.

The great powers over lunatic hospitals given to the Commissioners in Lunacy (Clauses 38 to 46) are objected to as being likely to check *charitable* effort in this direction, which in the past has done so much for the welfare of the insane.

We are unanimous in requesting the Lord Chancellor's attention to what appears to us the extreme severity of the penal clauses, which in some cases (as in Clauses 5 and 7) appear to be unjust. Penalties under these Clauses may be incurred by medical officers in regard to matters of which they have no power or opportunity of obtaining information. There is practically no distinction made between wilful and criminal infraction of the law, and omissions the result of inadvertence or forgetfulness.

The periods of time throughout the Bill (as in the present lunacy law), we beg to suggest, require definition; such terms as three days, and even three clear days, being somewhat uncertain. Also we would ask whether Sunday is a

dies non when falling within such periods. The date of the commencement of such periods of time requires to be specified when they involve the sending of a form or notice from one authority to another.

We beg permission to take this opportunity of drawing the attention of the Lord Chancellor to the following matters, which we regard as of the greatest importance in relation to the welfare of the insane, and which, we trust, will have the early consideration of the Legislature:—

The most important of these matters is the desirability of applying the present Government capitation grant (to pauper lunatics) to the maintenance of the asylums, and the payment of the salaries of the officers, &c., as suggested in a series of resolutions passed by our Association and printed in the “Journal of Mental Science” for 1883.

Also that the superannuation allowances of the officers and servants of pauper asylums should be placed on a more satisfactory footing, and should no longer be merely permissive. In relation to this matter we beg to submit a list of resolutions passed by our Association, in 1879.

And lastly, that provision should be made for giving clinical instruction in insanity in the county and borough asylums by the medical officers of those institutions.*

In conclusion we beg to thank his Lordship for having given us this opportunity of bringing our opinions under his notice.

HENRY RAYNER, M.D.,
President.

While we believe general consent will be given to the action taken by the Committee, a belief confirmed by the approval expressed at the very large Meeting of the Association, May 8th, there will no doubt be differences of opinion on certain points. Thus, not a few think that the working of the Scotch system in regard to the Sheriff’s order prior to admission will, if introduced into England, be accompanied by serious consequences. On the other hand it is hoped by others that good may come out of seeming evil; the endorsement of the magistrate lessening to a large extent the responsibility of the physicians signing the certificates. Dr. Yellowlees’s opinion was quoted at the above meeting to the effect that the Sheriff’s order removes responsibility from the shoulders of the medical signatories, except as regards

* The numbers of Clauses, &c., refer to the unamended Bill.

the accuracy of the facts stated and the soundness of the opinions expressed.

Whether the magistrate's order would relieve medical men as much as that of the Sheriff is alleged to do, has been much discussed. That it will have the same effect, is asserted by Lord Shaftesbury in his letter to the "Times" on his resignation of the Chairmanship of the Lunacy Board. Dr. Urquhart spoke strongly at the aforesaid Meeting in favour of the operation of this feature of the Scotch law which the Lord Chancellor desires to introduce into England. Dr. Hayes Newington, who has had experience of both English and Scotch law, spoke favourably of the latter in this respect, and doubted whether the serious consequences would flow from its introduction into England which some feared. To have the disadvantages arising from the delay and publicity involved in judicial or magisterial action, and no compensatory benefits in the direction of safe-guarding medical certificates, would be extremely unfortunate. If, then, we must have a legal functionary called in to determine whether an alleged lunatic shall be confined in an asylum or not, let his decision place the responsibility upon his shoulders. Two medical men have examined the patient and expressed their opinions, but here their duties end. They are of a purely professional kind. That this is a growing view cannot be denied, and it is quite certain that in proportion as it comes to be adopted and embodied in lunacy legislation, medical men will be willing to sign certificates. Be it always understood, however, that it is as impossible as it would be unjust to shelter our profession from wilful mis-statements or culpable carelessness in the examination of lunatics.

We had written so far when we became acquainted with the opinion of counsel on this point, obtained by the Committee of the British Medical Association. Of the medical men signing certificates he says, "If they take care to fill up their certificates in the manner provided by the Bill, they will, I think, be in the position of witnesses, and liable for the statements in their certificates, just as witnesses are liable for the evidence they give; that is, they will be criminally liable for making wilfully false statements, but not civilly liable for damages caused by statements given by way of evidence, though untrue, if given *bonâ-fide*. If the medical practitioner do not comply with the directions given as to his certificate, the document may fail to be what is

required by the Act, and so not be protected; but even then it would only be shown to the judge or magistrate in private; and I doubt whether this would amount to a publication, so as to render the signer liable to an action for libel. The protection afforded, therefore, seems to be sufficient, if the medical practitioner takes care to fill up his certificate in proper form."

In the opinion of Counsel the order of the judge or magistrate for detention in an asylum is "a judicial act" under this Bill. It will be seen, on reference to the 13th section of the 2nd clause, that "Every judge, magistrate, and justice, and all persons admitted to be present at the consideration of any petition for an order under this section, shall be bound to keep secret all matters which may come to his or their knowledge by reason thereof, except when required to divulge the same by lawful authority." Hence if the magistrate or judge decide that the certificates do not justify detention, the alleged lunatic cannot make use of the physicians' statements. They are to be kept secret. This fact has been strangely overlooked by some who have asserted that the Bill makes the position of physicians signing certificates ten times worse than it was before.

Since the above was written the Bill has gone into Committee, and the Lord Chancellor has introduced amendments which, if adopted, will materially improve the Bill. Indeed, we do not hesitate to say that, should it become law, medical men will stand in an infinitely better, instead of, as was feared, a worse position than they did before. They will be protected to an extent we had scarcely dared to expect. No reasonable man, in fact, can well deny that it is manifestly only right and fair that if any sign certificates in bad faith, they should be liable to an action, with its possible pains and penalties. All we ask is that no action should be commenced without the consent of the Attorney-General, in order to prevent vexatious actions on the part of discharged lunatics. We should also have been glad to see a clause introduced to the effect that the plaintiff should be required to give security for costs he may have to pay in the event of his losing his action. The Parliamentary Committee have suggested that this amended clause should be made distinctly to cover not only those who examine a patient and decide to sign a certificate, but those likewise who examine and do *not* sign. They should be protected from having entered a man's house against his will. The follow-

ing Clause, which largely meets the suggestions made by the Parliamentary Committee of the Association, is the first guard provided by the amended Bill:—

A medical practitioner who in the manner required by this Act signs any certificate that a person is of unsound mind, shall not be liable to any civil or criminal proceeding for signing such certificate, or for an act done with the view of enabling the practitioner to sign the certificate if the certificate is signed and the act is done in good faith. (Subsection 4 of Clause 8 in the amended Bill.)

It is satisfactory to have reason to believe that the representations made by the Association have been to a large extent the means of inducing the Lord Chancellor to insert this important amendment. We draw especial attention to the fact that it is so framed that not only does it protect the physician from the act of signing the certificate of Lunacy, but it covers, as it ought to do, the proceedings he may have been obliged to take in order to secure an examination of the patient. It is desirable to strengthen this clause by requiring consent of the Attorney-General, but every one who is engaged in lunacy practice ought to be thankful to the Lord Chancellor for the way in which he has met the wishes of the Association and the profession generally. It goes far to lessen, also, the objection so strongly felt to the severe penalties attached to the Bill, because it is clear, that if the amended Bill passes, it will be the fault of medical men themselves if they suffer from them.

There is still another safeguard. Subsection 3 of Clause 16 of the amended Bill* enacts that:—

“No prosecution for a misdemeanour under this Section shall take place except by the direction of the Attorney-General or the Public Prosecutor.”

The latter was the proposal of the Parliamentary Committee, and while it is felt that his judgment is by no means infallible, there can hardly be a doubt that it will act as a very real check upon vexatious actions.

Among other satisfactory amendments is one giving full

* Clause 16 of the Bill enacts that “any person who makes a wilful misstatement of any material fact in any medical or other certificate under the Act 8 and 9 Vict., cap. 100, or the Lunatic Asylums Act, 1853, or the Acts amending these Acts respectively, or under this Act, shall be guilty of a misdemeanour.” To this clause heavy penalties were attached in the original Bill, but in their place the above reference to the Attorney-General, &c., is substituted. No one can complain that wilful mis-statements should be liable to punishment.

permission to the medical men signing certificates to consult together about the case before the certificates are signed. Others, also very important, such as the delegation of the new functions of magistrates to certain of their number, need not be specified; they will be found in the Bill itself.

The proposed consolidation of the Lunacy Laws will, if effected, be an immense convenience.

Resignation by Lord Shaftesbury of the Chairmanship of the Lunacy Board.

As all our readers are aware, the introduction of a Lunacy Bill by the Government into Parliament, containing certain clauses to which the Earl of Shaftesbury strongly objected, induced his lordship to place his resignation of the Chairmanship of the Lunacy Board in the hands of the Lord Chancellor, by whom it was accepted. There has been but one feeling in consequence of the course which Lord Shaftesbury has deemed it his duty to pursue—that of extreme regret, accompanied by a fresh sense of the value of the services rendered by this philanthropic nobleman.

It will be seen from the report of the Quarterly Meeting of the Association that the proposal to take some definite action in reference to Lord Shaftesbury's retirement was discussed, but was postponed to the Annual Meeting. It was felt to be premature to act as if this retirement were altogether final—a step which might not be recalled—inasmuch as circumstances might happen in the direction of modification or withdrawal of the Bill which would lead his lordship to withdraw his resignation. We have no authority, however, for expecting the resignation to be recalled. We cannot, therefore, pass over so important an event in the history of lunacy in this country without joining in the expression of regret, so universally felt by those interested in the insane, and our appreciation of such lengthened labours in their behalf, in so many ways. It is not merely as the Chairman of the Board of Lunacy Commissioners that Lord Shaftesbury has deserved our grateful acknowledgments. To his success in this character, others immediately associated with him will bear witness. We may more properly refer to his Parliamentary career in relation to lunacy. When Lord Ashley, he took up the question of Lunacy legislation

at a critical time in the history of the insane in this country. It will be remembered that after the York Retreat had been in operation for some years, its success led to an inquiry into the condition of certain asylums in England and to the exposure of grievous abuses. Then came the Parliamentary enquiry of 1815, and fitful attempts at fresh legislation, but it was not until 1828 that Mr. Gordon and Lord Ashley succeeded in carrying through Parliament a Bill for the better provision and protection of the insane. It was then (57 years ago) that Lord Ashley began the work in which he has so honourably distinguished himself ever since. In this connection it is interesting to recall a sentence written by Sydney Smith in 1817. He says: "The new Establishment began the great revolution upon this subject, which we trust the provisions of Parliament will complete." That hope was fulfilled, and fulfilled chiefly through the exertions of Lord Ashley, who, in the speech in which he introduced his measure into the House, expressed himself, in referring to the York Retreat, in similar terms to those we have quoted from Sydney Smith. Seventeen years after the period referred to, he again came forward, and the Act of 1845, which has been called the Magna Charta of the Insane, was the result of his labours. That Act may not be perfect, indeed it has been supplemented by later ones in regard to minor points, but on the whole it was a beneficent Act, and wrought incalculable good for the pauper insane of this country.

What we wish, then, to emphasize is that although a better system of treatment had been introduced into England before Lord Ashley took up the subject, his lordship brought the law to bear upon the interests of the insane, and made it compulsory upon the counties to provide proper establishments for this class.

Then one word with regard to the Lunacy Board. That its appointment has been of great utility, and that Lord Shaftesbury has largely contributed to its success, we think few, if any, will deny. We feel, therefore, that on all grounds we ought to be most grateful to Lord Shaftesbury for his life-long work in a great cause among the many in the wide field of humanity to which he has consecrated his life. To this feeling fitting expression will, we are sure, be given at the Annual Meeting in August, should unfortunately, his lordship not be able, consistently with his convictions, to withdraw his resignation.

Conflict between Magistrates and Workhouse Authorities.

Wandering lunatics have had a hard time of it. They have been sent from pillar to post—from the workhouse to the magistrate, and from the magistrate to the workhouse—in a manner quite unprecedented, and with results very detrimental to the unfortunate lunatics. We hear of suicides in consequence, and of the insane being locked up in the cells of police stations till a decision is arrived at, the patients in some instances being found in a critical state next morning, as in the instance of Wise, the platelayer on the Great Western Railway. Here, the Acton relieving officer took the usual proceedings before the Court, and obtained an order for his admission into the workhouse at Isleworth. The authorities refused to admit him, and he was detained at the police-station in charge of constables. In the morning his condition was alarming; the divisional surgeon was sent for, and he found him labouring under apoplexy.

The immediate occasion of all this trouble is the judgment delivered by Mr. Justice Wills in the case of *Hicks v. Bedford*. The plaintiff was confined in the lunatic ward of the Marylebone Workhouse for a fortnight without the formalities required by the 16 and 17 Vict., c. 97, sec. 68, having been observed. The Judge merely gave effect to the strict letter of the law; the workhouse authorities following the customary practice in such cases. The patient was admitted, it will be remembered, with a medical certificate, but without any order from a magistrate. Hicks, of course, gained his action. The consequence was that many patients were at once discharged from workhouses, and, as we have said, many wandering lunatics were refused admission. A German waiter, Knabe, was brought to the Southwark Police Court belonging to this category, and labouring under acute mania. He was brought there because the officials at the workhouse had refused to admit him, on the ground that there was not a full compliance with the Act as laid down by Mr. Justice Wills. Mr. Lloyd, the surgeon to the Lambeth Infirmary, was undoubtedly justified and was prudent in advising that Knabe should not be admitted. Mr. Bridge, the magistrate, took a different view, and held that this case was not similar to that of Hicks. Subsequently Mr. Barker, the assistant-overseer in Lambeth parish, waited on Mr. Bridge. The former was accompanied by Mr. Fraser, the solicitor to the

Guardians, and by Mr. Lloyd. The patient was admitted at Mr Barker's urgent request, and then sent to Brookwood. Mr. Barker had been to the Local Government Board, and was told that the Government would introduce a clause into the Lunacy Bill, making the law clear in regard to workhouses receiving patients.

It is satisfactory to find that this promise has been fulfilled, another proof that the Lord Chancellor is willing to introduce reasonable amendments into his Bill.

The following is the clause referring to the

Removal of a Lunatic to Workhouse in Cases of Urgency.

“ Clause 12 :—

“ Where a constable, relieving officer, or overseer has knowledge that there is within the limits of his jurisdiction a person alleged to be a lunatic, for whose immediate care and maintenance relief appears to be requisite, and the constable, relieving officer, or overseer is satisfied that it is urgently necessary for the welfare of the alleged lunatic, or for the public safety, that the alleged lunatic should be forthwith placed under care and treatment, the constable, relieving officer, or overseer may remove the alleged lunatic to the workhouse of the Union in which the alleged lunatic is, and the master of the workhouse shall, unless there is no proper accommodation in the workhouse for the alleged lunatic, receive and relieve and detain him therein ; but no person shall be so detained for more than forty-eight hours, unless in the meantime the provisions of this Act relating to the detention of lunatics in workhouses have been complied with.”

See also Clauses 13 and 14.

The above gives ample opportunities for the examination of lunatics in workhouses. Other clauses (Clauses 5 and 10) give clear instructions to constables and relieving officers how to proceed in the case (1) of lunatics not under proper control or care, and cruelly treated or neglected ; and (2) in regard to lunatics dangerous to public order.

Suicides in England and Wales.

We have often had occasion to observe that on this important subject the ideas prevalent in even the medical profession are to the last degree indefinite, and that very few have taken the trouble to obtain information based upon reliable statistics. It is one in which, at any rate, the statistical method of enquiry can be pursued with success ;

in fact, without it, any conclusion arising from general impressions is certain to be incorrect.

We call attention to the following carefully-prepared tables,* which convey information not previously worked out in this form. The reader will find: (1) The number of suicides at different ages in England and Wales during 23 years, 1861-1883, distinguishing the sexes. Returns are given also for groups of years as well as for each year. (2) The proportion of suicides to 1,000,000 living, at different ages, distinguishing the sexes.

Among the various results to which these tables lead may be noted the following:—

Number. There are annually upwards of 1,900 persons who commit suicide in England and Wales, or more than 70 per million persons living. The highest proportion reached in the course of a year during the 23 years has been 80 per million; the lowest, 61. There has been a fairly progressive increase from 65 in the first quinquennium to 74 in the last three years under review.

The following figures show at a glance the increase or decrease per cent. of suicides among equal numbers living at different ages during 1861-70 and 1881-3:—

Ages.	Persons.	Males.	Females.
All Ages.	12·1 ...	14·1 ...	8·8
15— ...	10·3 ...	7·1 ...	9·7
20— ...	9·1 ...	6·8 ...	9·7
25— ...	21·0 ...	16·1 ...	22·9
35— ...	23·6 ...	25·0 ...	17·0
45— ...	8·2 ...	9·1 ...	0·0
55— ...	9·3 ...	9·3 ...	16·1
65— ...	17·1 ...	23·1 ...	0·0
75 and upwards	25·5 ...	41·4 ...	—17·1

It will be seen that at all ages there is an increase, except in females at 75 and upwards.

Sex. Distinguishing the sexes it will be observed that the number of females who commit suicide is much less than that of males. We believe, however, that if the number of men and women who contemplate self-destruction—who, in short, are *suicidal*—could be ascertained, the disproportion would not be so great. Many more women than men desire

* By Mr. J. H. Shoveller, Somerset House.

or think they desire, but have not the courage to cause, their own death. This does not, however, admit of statistical verification. The tables show that while from 1861 to 1883 (inclusive) 22,954 men committed suicide, only 8,022 women did so. During 1883, 1,445 men and 517 women destroyed themselves. The maximum number of females was 519 (in 1882), the minimum 345 (1863), during our period of three-and-twenty years. Calculated on the million persons living, we see that in 1883 the ratio of male to female suicides was as 111 to 38, or during the whole period about 105 to 35. The proportion of female suicides between 15 and 20 was greater than among males at the same age, but between 20 and 25 the latter much preponderated, which is contrary to what Morselli lays down as the rule. The result as to the liability of the sexes may be summarised thus:—Among equal numbers living of both sexes there were exactly three male suicides to one female during 1861-83.

Age. We think the impressions many have as to the period of life most liable to suicide will differ from and be rectified by these figures. It will be seen that the largest number of persons commit suicide during the decennium between 55 and 65 in both sexes, and that the proportion is only slightly less between 65 and 75. Nor would it have been supposed that the proportion at the age of 75 and upwards is greater than that between the ages of 35 and 45 in females, and 45 and 55 in males. For "Persons," it is not much below the proportion during the latter decennium; in fact, it was greater during the ten years 1871-1880, the ratio being 183 in old people, and 175 at the ages of 45-55. It was a trifle greater also during the three years 1881-1883.

Sex in relation to age. The tendency to suicide as age increases is the most striking in regard to males. Here, although the maximum liability is attained between 55 and 65, as with persons of both sexes, it is as great between 65 and 75, and is actually higher then during several periods, namely, the decade 1871-1880, and during the three years 1881-1883. With women the proportion of suicides between the ages 65-75 was once greater than between the ages 55-65, viz., during the five years 1871-1875; but during the other periods this was not the case.

Other points of interest present themselves in connection with suicides, to which we propose to return in a future number.

TABLE I.
Number of Suicides at Different Ages in England and Wales, 1861-1883.

Years.	PERSONS.						MALES.						FEMALES.						Years.												
	All Ages.	Under 15.	15-20.	25-35.	45-55.	65-75 and upwards.	All Ages.	Under 15.	15-20.	25-35.	45-55.	65-75 and upwards.	All Ages.	Under 15.	15-20.	25-35.	45-55.	65-75 and upwards.													
1861-1880	30976	169	1184	1887	4443	5731	6797	6312	3434	1019	22954	93	566	1195	3152	4292	5114	5034	2720	788	8022	76	618	692	1291	1439	1683	1278	714	231	1861-1880
1861-1870	14009	84	595	850	1957	2608	3167	2827	1489	432	10302	47	280	534	1383	1935	2367	2263	1175	318	3707	37	335	316	574	673	800	564	314	114	1861-1870
1871-1880	16967	85	589	1037	2486	3127	3630	3485	1945	587	12652	46	286	661	1769	2357	2747	2771	1545	470	4315	39	303	376	717	766	883	714	400	63	1871-1880
1861-1865	6715	39	290	414	902	1261	1549	1350	696	214	4933	20	135	255	650	942	1142	1077	551	161	1782	19	153	159	252	319	407	273	145	53	1861-1865
1866-1870	7294	45	305	436	1055	1347	1618	1477	793	218	5369	27	145	279	733	993	1225	1156	624	157	1925	18	160	157	322	354	393	291	169	61	1866-1870
1871-1875	7720	40	269	452	1119	1443	1606	1605	907	279	5715	24	132	278	799	1096	1197	1255	699	225	200	16	137	164	320	347	409	350	208	54	1871-1875
1876-1880	9247	45	320	585	1367	1680	2024	1880	1038	708	6937	22	154	373	970	1261	1550	1516	846	248	2310	23	166	214	387	419	474	364	192	63	1876-1880
1881-1883	5882	31	252	338	863	1177	1228	1158	643	192	4367	17	118	213	692	889	935	909	526	158	1515	14	134	125	261	288	293	249	117	34	1881-1883
1861	1347	9	51	89	167	215	336	293	140	47	982	5	22	55	127	158	242	228	110	35	365	4	299	34	40	57	94	65	30	12	1861
1862	1317	4	72	77	180	247	295	250	143	49	960	2	34	46	119	187	221	204	112	35	357	2	38	31	61	60	74	46	31	11	1862
1863	1319	9	54	86	151	261	318	252	147	41	974	4	24	45	106	211	240	196	117	31	345	5	26	30	41	50	78	56	30	10	1863
1864	1340	4	62	81	215	285	294	243	116	40	993	2	36	53	159	199	220	202	89	33	347	3	25	28	56	60	74	41	27	7	1864
1865	1392	13	51	81	189	253	306	312	150	37	1024	7	19	56	139	187	219	247	123	27	368	6	32	25	67	67	87	65	27	10	1865
1866	1329	6	64	84	185	248	290	272	138	39	951	5	23	61	167	223	226	219	166	44	388	4	31	33	61	67	67	58	34	16	1866
1867	1316	4	64	83	193	282	309	248	154	29	963	3	28	47	133	171	233	207	117	24	353	1	22	36	60	61	76	41	37	5	1867
1868	1508	18	50	86	233	286	332	304	151	48	1117	11	28	61	166	204	245	248	120	34	391	7	22	25	67	82	87	56	31	14	1868
1869	1587	12	70	92	217	313	337	322	175	49	1178	5	37	67	154	240	251	253	138	35	409	7	33	35	63	73	86	71	37	14	1869
1870	1554	5	57	91	234	268	300	331	175	53	1160	3	29	53	153	197	273	266	145	41	394	2	30	31	58	75	71	68	40	13	1870
1871	1495	7	56	78	225	291	328	302	155	53	1103	4	26	47	167	216	254	234	115	40	382	3	23	34	73	69	89	66	51	11	1871
1872	1514	9	47	91	211	290	328	298	186	47	1065	6	24	57	138	221	246	232	135	36	419	3	23	34	73	66	78	75	41	11	1872
1873	1518	8	53	88	216	287	311	317	180	58	1129	4	23	61	159	221	233	242	139	47	389	4	23	34	73	68	86	69	39	10	1873
1874	1592	7	55	93	227	291	312	318	205	54	1204	3	22	59	168	215	238	268	144	58	417	2	31	43	72	69	82	72	37	9	1874
1875	1601	9	58	102	240	284	320	340	181	67	1184	7	27	59	187	249	257	286	156	55	458	8	38	46	62	85	105	72	35	7	1875
1876	1770	12	78	124	249	331	362	358	191	62	1312	4	40	78	186	230	298	279	171	50	388	2	27	42	74	72	67	54	40	10	1876
1877	1689	6	52	110	260	302	365	323	211	60	1311	4	25	68	186	230	298	279	171	50	388	2	27	42	74	72	67	54	40	10	1877
1878	1764	10	64	115	255	307	402	382	173	56	1299	5	32	74	177	229	303	298	137	44	465	5	32	41	78	78	99	84	36	12	1878
1879	2035	14	62	121	315	385	450	390	225	73	1519	7	28	78	224	286	354	350	186	53	516	7	34	43	91	99	96	87	39	24	1879
1880	1979	3	62	115	288	352	445	417	238	57	1496	2	29	75	196	267	338	350	196	43	483	1	35	40	92	85	107	67	42	14	1880
1881	1955	12	86	101	293	371	429	384	216	62	1476	6	41	64	210	291	332	301	182	49	479	6	34	40	92	80	97	83	34	17	1881
1882	1965	13	78	118	284	376	411	385	222	79	1446	7	40	72	200	273	307	308	177	62	519	6	38	46	83	103	104	77	45	17	1882
1883	1962	6	88	119	286	430	388	389	205	51	1445	4	37	77	192	275	296	300	167	47	517	2	51	42	94	105	92	89	38	4	1883

TABLE II.

Suicides to a Million Persons Living at Different Ages in England and Wales, 1861-1883.

Years.	PERSONS.										MALES.										FEMALES.										Years.
	All Ages.	15	20	25	35	45	55	65	75 and Upwards.	All Ages.	15	20	25	35	45	55	65	75 and Upwards.	All Ages.	15	20	25	35	45	55	65	75 and Upwards.				
1861-1883	69	28	47	68	113	175	237	230	170	100	27	62	100	177	274	397	397	305	35	29	33	38	55	83	93	87	86	1861-1883			
1861-1870	66	29	41	62	106	171	226	211	149	99	24	59	93	164	263	377	359	251	34	31	31	35	53	84	87	83	70	1861-1870			
1871-1880	70	28	48	70	114	175	241	242	183	107	24	64	104	179	277	409	417	336	35	26	33	39	53	84	95	92	61	1871-1880			
1861-1865	65	29	44	59	105	173	224	205	152	98	27	58	90	165	262	371	350	263	34	31	32	38	54	79	87	86	72	1861-1865			
1866-1870	66	29	45	65	107	168	229	213	116	100	28	60	96	165	264	383	390	333	241	34	30	30	36	50	78	96	99	62	1866-1870		
1871-1875	66	24	43	65	109	160	234	233	185	111	26	70	111	185	302	433	442	343	26	27	26	42	57	85	94	86	67	1871-1875			
1876-1880	71	26	52	75	119	185	247	247	187	113	30	63	108	205	287	412	442	353	37	31	31	43	62	84	101	83	58	1876-1880			
1881-1883	74	32	48	75	131	185	250	212	171	100	23	61	91	138	256	403	361	293	35	30	35	46	62	84	101	83	58	1881-1883			
1861	67	26	49	56	91	164	167	210	211	176	97	35	84	162	258	356	361	290	34	38	32	39	49	82	75	86	89	1861			
1862	65	37	41	60	104	167	210	211	176	97	35	53	84	162	258	356	361	290	34	38	32	39	49	82	75	86	89	1862			
1863	64	27	46	49	108	178	209	168	146	97	24	51	74	182	276	337	372	256	32	28	28	35	68	85	90	82	63	1863			
1864	64	31	43	70	117	162	199	168	140	98	36	60	109	170	250	343	279	266	32	26	28	35	68	85	90	82	63	1864			
1865	66	25	43	61	103	166	232	214	128	99	19	62	94	159	245	414	379	215	34	31	25	31	52	92	101	72	61	1865			
1866	62	31	44	60	100	155	217	194	134	91	27	51	88	143	254	339	349	186	32	34	35	40	63	88	93	82	63	1866			
1867	61	31	43	60	93	163	195	213	98	91	27	51	88	143	254	339	349	186	32	34	35	40	63	88	93	82	63	1867			
1868	69	24	44	72	114	173	235	207	160	105	27	66	108	169	264	401	353	261	35	21	24	37	55	85	104	93	82	1868			
1869	71	33	47	66	123	173	246	235	162	109	35	72	99	198	267	401	400	265	36	31	24	37	55	85	104	93	82	1869			
1870	69	26	46	68	105	177	219	231	173	99	27	56	97	161	286	419	413	306	34	27	29	33	56	73	96	98	76	1870			
1871	66	25	48	67	103	168	224	205	175	99	24	49	105	174	272	367	380	304	34	26	29	33	56	73	96	98	76	1871			
1872	66	21	30	62	111	169	208	242	153	97	22	58	85	176	260	369	382	272	35	20	32	41	51	86	92	103	61	1872			
1873	65	23	42	63	108	155	229	231	187	99	20	62	97	174	243	369	388	272	35	25	26	32	48	75	103	98	62	1873			
1874	64	24	44	65	108	153	218	260	172	104	28	61	101	173	232	420	457	322	32	20	26	38	39	49	84	92	92	56	1874		
1875	67	25	48	68	104	148	239	227	210	101	23	58	100	164	241	398	391	418	34	26	38	39	49	84	92	92	56	1875			
1876	73	32	57	70	121	172	249	236	192	111	34	76	110	188	257	419	418	391	37	32	41	33	59	96	95	80	38	1876			
1877	69	22	50	72	108	172	229	257	183	109	21	65	108	171	264	403	452	351	31	22	27	39	50	61	70	90	54	1877			
1878	70	26	52	70	108	187	258	268	169	107	26	70	101	168	265	425	358	305	36	26	35	41	53	89	108	80	64	1878			
1879	80	25	54	85	134	207	260	267	217	123	23	73	126	207	340	427	479	362	40	28	36	47	66	85	110	86	105	1879			
1880	77	26	50	76	121	202	275	279	167	120	23	69	109	191	321	486	498	321	37	28	33	47	66	93	84	91	73	1880			
1881	75	34	43	77	126	197	249	253	184	116	32	57	115	205	323	415	465	335	38	35	30	42	52	85	102	73	68	1881			
1882	74	30	50	73	126	186	247	256	231	113	31	64	108	189	292	419	416	419	38	29	37	41	67	90	93	96	88	1882			
1883	73	34	50	73	142	173	246	233	147	111	28	67	102	222	278	403	415	313	38	39	31	46	67	78	105	80	20	1883			

PART II.—REVIEWS.

Endemic Goitre or Thyreocoele (including its Relations to Cretinism and Allied Disorders). By WILLIAM ROBINSON, M.D.Dur. 1885. J. and A. Churchill. pp. 66.

Perhaps the most difficult task which a scientist, and more especially a medical man, might attempt at the present day, is to endeavour to free himself from the engrossing slavery which compels him to follow his favourite subject, and to devote himself to the task of forming generalizations on the hosts of facts which are being daily, nay, almost hourly accumulated. Detailed information on the structure and function of many of the different organs is now produced in such quantities that it almost appears to necessitate a kind of scientific specialism on many subjects. Fortunately the very subjects which would suffer most from such a condition of things are just those which either involve so many side issues as to make it almost impossible to take a narrow view of them, or else have been so incompletely investigated as to leave the whole question perfectly open. Such a subject is that of the relation of goitre to cretinism, especially considered with regard to the causation of cretinism and the allied causes of idiocy. Although goitre and cretinism have for centuries been known to run on closely parallel lines, still the idea that they might stand in a causal relation to one another has only recently been suggested, and still more recently only demonstrated to be possible. It is an extraordinary thing that although the frightful prevalence of cretinism in Alpine districts caused the Governments of Northern Italy and of France to dispatch from time to time Commissioners of the highest scientific ability to enquire into the clinical features of the cretinic condition, and to endeavour if possible to discover its cause, it does not seem to have occurred to the authorities engaged that the real key to the problem was the study of the pathological changes in the persons affected. For this reason, although an immense amount of very valuable negative evidence has been amassed, it only goes to show that goitre (and the same thing is nearly true for cretinism) may appear in any part of the world, and under almost any circumstances. In fact, as far

as our information from the above-mentioned researches into climatology went, we knew practically nothing more of the etiology of goitre and cretinism than that it is more liable to occur in hilly districts of a cretaceous formation than in other places. Matters were in this state when Mr. Curling and Dr. Hilton Fagge drew attention to the cases of so-called sporadic cretinism as they were met with in England. Sporadic or congenital cretinism appears to be of two distinct kinds, namely, one kind in which a child at birth is found to present the most marked cretinous changes, being also invariably (that is in all cases reported up to the present date) born dead, and another kind in which the child is born apparently quite normal, but at a very variable period, from a few weeks to a few years, after birth begins to show symptoms of commencing cretinism which soon reach a maximum. In all cases examined post-mortem the thyroid body was either absent (as in the large majority of instances) or was the seat of a goitre, but if any portion of the gland remained, it was apparently never examined microscopically.

At the present time, therefore, we are justified in saying that wherever cretinism has appeared in England, and has been thoroughly examined, the thyroid body has been found to be either destroyed or abnormal. Dr. Robinson has contributed three valuable cases to the clinical history of this subject, with a dissection of the neck in one instance in which the thyroid body was found to be absent. Soon after cretinism had been thus studied as it occurred in English children, the subject was further elucidated by the clinical observations of Sir William Gull, who described what he called adult cretinism occurring in women, a condition which, in its commonest form, received the name of myxœdema, from Dr. Ord, who really was the first to give a complete account of the disease. The group of symptoms which have now become so familiar under this title need no further notice here than the remark that they may be summed up under the terms imbecility and mucoid degeneration. The relation of the latter point (namely, the accumulation of mucin in the tissues) to cretinism will be discussed further on as one of as yet unappreciated importance; and, meanwhile, reference must now be made to the condition of cretinism as we see it artificially produced by surgical operation or pathological experiment. The Swiss surgeons, who are so familiar with

the goitrous and cretinic conditions, noticed that in cases of persons from whom they had completely removed the goitrous thyroid gland there ensued all the symptoms of cretinism as it appeared to them. These facts were published more especially by Kocher and the two Reverdins. Although the operation of extirpating a goitre cannot be considered as an exact scientific experiment, yet the clinical history of the cases shows that only very rarely were the deep important cervical structures, viz., vessels and nerves, injured, and so we may assume that this artificial myxœdematous or cretinous condition was produced by destroying the functional activity of the thyroid gland. This view of the case was not, however, entertained seriously by Kocher or other German surgeons who took up the subject, they believing that the symptoms were entirely due to a state of chronic asphyxia produced by stenosis of the trachea, caused by the pressure of the tumour, &c. The inadequacy of this view will be very obvious when it is remembered how often cases of laryngeal disease endure much more severe chronic asphyxia without developing the myxœdematous or cretinous state. To settle the question, it was obviously necessary that the operation of thyroidectomy should be performed on the lower animals, with the view of finding whether the cretinous myxœdematous state followed absolutely the loss of function of the thyroid body, or whether it was due to injury of the sympathetic and other nerve trunks, or of the air passages. Numerous experiments on the Continent were made by Schiff, Wagner, Sanguirico, and Canalis; these observers employing dogs and cats as the subjects of experiment, and it was very speedily found that the loss of the thyroid body was invariably fatal to the animal which suffered the same, death being preceded by violent tremors leading to tetanus, while, at the same time, the animal became more and more stupid and imbecile, ultimately dying comatose. The carnivora, however, do not appear to survive the operation more than about a fortnight on the average. Thyroidectomy was then performed on monkeys by Horsley, who found that the animals which survived for two or three months became decidedly cretinous and myxœdematous. For a few days after the operation (the wound healing in three days), the first symptom appeared in the shape of tremors, and at the same time the animal became anæmic, the connective tissues swollen, and loaded with mucin. And then increasing hebetude and imbecility led the way to death by coma. Horsley

proved that the condition was not due to injury of the large nerves or air-passages.

We are now in a position to review afresh the relation of goitre to cretinism, always remembering the possible occurrence of myxœdema. It was long ago pointed out by Foderè that goitre and cretinism must be causally related, and Bailarger's facts also point strongly in the same direction. It is rather annoying to feel, however, that this extremely important point remains unsolved, simply because we have not to hand any records of systematic macroscopic and microscopic examination of the thyroid body in cretins; and we may hope that the increased stimulus given to the subject by the publication of the occurrence of *cachexia strumaprima*, as Kocher called the cretinoid state following total excision of goitres, may induce Continental pathologists (who have the opportunity) to fill up this gap in our knowledge. Meanwhile we can only study very closely the conditions which are severally distinguished under the names of cretinism, myxœdema, *cachexia strumaprima*, and what we may call artificial myxœdema. The clinical history of each of these conditions is (with a few exceptions presently to be noted in detail) exactly similar. Thus in all there are preliminary nerve-symptoms which usher in the well-known imbecility that is such a striking feature of these conditions; the mental state in all is extremely similar, so that the one classical description of cretinism could be applied, only varying in degree, to each of the above-mentioned states; and, finally, there are closely-allied retrograde changes in the various connective tissues in each kind of affection. Perhaps this last we may call the most suggestive symptom, because it carries on the face of it tangible evidence of grave constitutional change, and therefore holds out promise that, by working backwards, we may arrive at the indirect cause. It is worth while to observe that the thyroid body, the loss of which is fairly established to be the immediate cause of the above-mentioned conditions, has a double function, viz., firstly, its proper glandular function, and, secondly, a hæmatogenous duty (Horsley). If we have loss of such a double acting organ it is extremely likely that the destructive changes which might be brought about in the tissues as a direct result of the loss of its function would be very considerable. It would not be right to assume from the foregoing evidence that all the symptoms were a simple consequence of the loss of the thyroid gland, especially as we have yet to learn the

reason of the destructive—commonly cirrhotic—atrophy of this gland. While on this point it may advantageously be remembered that the cause, whatever it may be, is distinctly hereditary in these districts where it largely prevails, and that the birth of cretinous progeny can be avoided by emigration from the affected district. It is perfectly conceivable therefore that insanitary or climatological conditions, which appear to determine the occurrence of goitre or cretinism in these cases, do actually bring about one or more of these affections in certain instances. But although such a conclusion is logically inevitable, and although the attention of scientists has been directed for a hundred years to this very point, we do not yet know what these insanitary or climatological conditions are. Dr. Robinson shows, in a valuable table constructed from a paper on the subject by Prof. Lebour, that the geological position of goitre *par excellence* is the carboniferous limestone. Beyond this we know nothing positively save that the disease also occurs, only to a less degree, on other geological formations as well.

We have noted above as a most important and suggestive symptom the degenerative changes which occur in the connective tissues of persons affected with cretinism, myxœdema, &c., and would call attention to the fact that if the process of destruction of the thyroid gland is extremely slow, as frequently happens in the fibro-cystic state, then the degenerative changes will be correspondingly slightly marked and slowly developed. If, on the other hand, the gland is destroyed quickly (as happens with the atrophy in myxœdema), the retrograde changes in the tissues are so rapid as to lead to the accumulation within them of proportionately large quantities of mucin. Thus it happens that we hear of cases (like those lately described by Routh and Sidney Phillips) in which a cretin is distinctly myxœdematous, while later in life the mucoid condition gradually disappears, to be replaced probably by a fibroid material. Dr. Robinson's treatise (which was his graduation thesis) shows that he has been able to bring a large amount of practical acquaintance with the clinical features of goitre and cretinism to bear on the study of their etiology, and he lends all the force of his experience to support the view that the loss of the function of the thyroid is the immediate cause of these conditions.

The Microtometist's Vade-Mecum. By ARTHUR BOLLES LEE. J. and A. Churchill. London: 1885.

This compact volume of under 500 pages contains all that is required by the practical section cutter. The author himself recognises the fact that the book is rather for the instructed anatomist than for the student. This is a good thing to begin with, for so many books now are addressed only to students. In some cases the ripe experience of many years is lucidly laid before the student, but in more instances the rapidly collected observations of the young teacher are published both for his own convenience in teaching and as an advertisement of his doings.

The book before us consists of a very complete collection of the methods pursued by recognised masters in their art, and very great pains have been taken to verify the descriptions of processes.

At present hardening of tissues, and specially the nervous tissues, is an art which cannot be perfectly taught by books. There are stages of experience which can only be passed through, and cannot be made sure by description alone. To the practical microtometist the *Vade-Mecum* will supply a kind of dictionary of his art, and will suggest fresh methods to him in the pursuit of his special hobby. After a clear introductory chapter, the first part of the book consists of lists of the various agents required for fixing, for hardening, for staining, washing, cleaning, and mounting the various tissues. Each of the above processes is fully considered, and the many variations in each process given, and, what is very useful in addition, the author gives his experience and opinion on the respective merits of some of the processes. Though these formulæ are very numerous, yet when looking over the logwood stains, we were surprised to find "hæmatoxylin" taking the place of the old fashioned watery extract of logwood. Many reasons exist for the use of the old preparation, among these being cheapness and abundance.

Full directions are given for bacteria staining, and now-a-days this alone is a very special part of the pathologist's education.

After the consideration of staining materials, hardening agents are reviewed, and then comes a chapter on imbedding, with a word on microtomes. But a dozen

years ago in England, few knew anything about section cutting, and the first teacher in London scorned any mechanical aid to cutting. Now-a-days all this is changed, and microtomes of every description abound. Our author hardly does justice to the English inventors of microtomes, for some most delicate though costly instruments have been turned out of Cambridge; but he, no doubt, considers when he has said that for the zoologist the freezing microtome is useless he has said enough. In other chapters every part of the process of preparing, cutting, and mounting are discussed with praiseworthy care and fulness.

In Part 2 special examples are given of the methods of preparation best adopted for the various organs or tissues.

Cell structures and functions are examined, and in order the embryological and mature tissues. As we are specially concerned in nervous tissues and the nerve organs, it may be well to say that the methods for examining both the nervous tissues and their elements, and also the nervous centres is complete.

The methods for preserving the brain whole, and the methods for hardening, for section cutting, are fairly clear and accurate. The methods most in favour depend on chromic acid and the chromates.

We do not notice any reference to Sankey's method of staining, drying, and shaving down, though Bevan Lewis's method, which has recently been considered clumsy, is given.

This is hardly the place to enlarge upon the importance of systematic investigation of the nervous tissues on a uniform plan; but the more simple such investigations can be made the more chance of good results following. One of the dreams of our youth, and a fading dream of maturer years, was that some central establishment for pure research into the pathological conditions occurring in the brain of the insane might be formed under the guidance of the Medico-Psychological Association, but the genius for this has not yet arisen.

We commend this practical little book to the notice of our readers.

La Législation relative aux Aliénés en Angleterre et en Ecosse.
Par le DR. A. FOVILLE. Paris, 1885.

Our readers will remember that several years ago a deputation appointed by the French Senate visited this country in order to make themselves acquainted with the English law of lunacy, and to visit the asylums in Great Britain which best represented the various classes of institutions devoted to the care and treatment of the insane. (See this Journal, Jan., 1884.)

It should be stated that in March, 1881, the French Government appointed an extra-Parliamentary Commission, of which Dr. Foville was a member, to consider and propose what revision might be called for after the lapse of 43 years in the law of 30 June, 1838, a statute, let us say in passing, which is highly creditable to those who enacted it. Among those who assisted in its preparation was Ferrus, who visited England in 1833 in order to obtain information in regard to our asylums and legislation at that period.

At the time of the medical congress held in London in 1881, Dr. Foville, at the instance of the Minister of the Interior, visited a number of institutions for the insane, with a view to forward the objects of this Commission. In November, 1882, the French Government brought in a Bill for the revision of the Lunacy Law. This was referred by the Senate to a Commission which decided to comprise in its investigation a practical examination of some of the asylums of other countries and the study of their Lunacy Laws. They visited Britain in October, 1883, accompanied by Dr. Foville. The work before us is the result of Dr. Foville's two visits.

There is an admirable sketch of the success in reforms introduced into England and Scotland with a view to the proper provision for the insane, and their care and humane treatment. It is remarkable how completely the author has succeeded in mastering the details of this history. He has, at the same time, incidentally referred to the parallel work, carried on in France at the close of the last century, and his comment is very happily and truly stated.

"Pinel, qui, dès 1793, avait entrepris la réforme du régime des aliénés en France, en faisant tomber les fers des malades enfermés à Bicêtre, fut mis, pour la première fois, par cet article de journal,* au courant des travaux de William Tuke —et de la fondation de la Retraite d'York. Il paraît que,

* "Bibliothèque Britannique," 1798. Article par le docteur Delarive.

de leur côté, les fondateurs de cette maison ignorèrent, jusqu'en 1806, l'initiative prise en France par Pinel.

"Ces deux bienfaiteurs de l'humanité ont donc poursuivi un but identique, chacun de leur côté et à l'insu l'un de l'autre, à une époque voisine de celle où Daquin en Savoie, Chiurugi en Italie, entreprenaient, dans leurs pays respectifs, une œuvre analogue. Bien loin de chercher à établir, entre ces divers réformateurs, une rivalité de gloire et de mesquines questions de priorité, la postérité doit réunir leurs noms dans un hommage commun d'admiration et de respect." (p. 19.)

As Dr. Foville occupies himself chiefly with a description of the laws in England and Scotland bearing upon lunacy, and the manner in which they are carried out in asylums, there is nothing which would be novel to our readers in this sketch. The book, however, will be read with interest, and we do not hesitate to say with profit, by Englishmen. His statements are characterised by conscientious accuracy; and occasionally a remark of the author's shows how thoroughly he has appreciated the bearing of the legislation he describes, and how clearly he perceives the delicate points of difference between British alienists themselves.

In conclusion, we would cite the summary with which Dr. Foville closes his work, and in taking leave of our eminent *confrère*, we would thank him for the friendly spirit in which he has sketched his impressions, and would also congratulate the Commission and the Senate on their good fortune in having obtained the services of so acute an observer, so candid a critic, and so lucid a writer.

"Il permet de constater que la législation relative aux aliénés est, en Angleterre et en Ecosse, plus perfectionnée à certains égards qu'elle ne l'est en France. Elle offre donc des exemples utiles à imiter, et dont il serait à désirer que l'on profitât, au moment où l'on travaille à la revision de la loi du 30 juin 1838.

"D'autre part, la loi du juin 1838 présente certains avantages incontestables sur les législations anglaise et écossaise. Deux dispositions de la loi française doivent être signalées sous ce rapport :

"1°. En France, toute personne placée dans un asile peut, par le mécanisme le plus simple et le plus économique, réclamer de l'autorité judiciaire l'examen de son état mental, et faire décider, par les tribunaux, si elle doit être maintenue dans l'établissement, ou si elle peut être rendue à la liberté; et ce n'est pas seulement la personne placée, qui peut pro-

voquer cet examen, n'importe qui peut en prendre l'initiative à sa place.

"2°. Les intérêts pécuniaires de tous les malades placés dans les établissements publics d'aliénés, surtout ceux des aliénés les moins favorisés de la fortune, intérêts qui, souvent très minimes d'une manière absolue, n'en ont qu'une importance relative plus considérable, sont protégés, gratuitement par le service d'administration provisoire confié aux commissions de surveillance ou administratives des établissements publics.

"Pour ne parler que de ces deux dispositions, on peut affirmer qu'elles sont entièrement dues à l'initiative du législateur de 1838, et qu'elles ont suffi pour imprimer à son œuvre un caractère, de libéralisme éclairé, que d'autres lois ont pu imiter depuis, mais qui n'a été dépassé par aucune." (p. 203.)

The truth of this comparison cannot be denied. We have never seen it so forcibly stated before in print. It is very clear that in the particulars here referred to, we have need to copy the French and not the French to copy us.

This work, although written for a temporary object, will retain its value as a historical production so long as the history of the insane possesses any interest for mankind.

De l'Aphasie et de ses Diverses Formes. Par Dr. BERNARD.
Paris. *Publication du Progrès Médical.* 1885, pp. 268.

Several distinguished French and Swiss savants have from time to time expressed the opinion that there must ultimately be devised a cosmopolitan language, and that it will probably be based on the Anglo-Saxon mode of speech. This idea comes home to us with particular force, when we are reminded, as in the above work, of the steady progress which is being made in the localisation of the various motor functions of the brain, and it seems a pity, for several reasons, that all nations do not use the same motor signals to express their thoughts. For were it so it would follow that ultimately we should be able, as cases accumulated, to narrow down to perfect accuracy the situation of each corpuscle, or group of corpuscles, which are told off, as it were, to utter each individual sound or write each special symbol. Such an extreme view of localisation of cerebral function we are sure will not escape the charge of being fanciful; but we

would point out that it is nothing but the logical conclusion to which we are driven, seeing that as cases are daily being examined with more and more care, and the position of the lesions in each instance determined with greater accuracy, *astonishingly exact delimitation of function to small groups of corpuscles and fibres is found to exist.* Another very obvious want for which the use of a cosmopolitan language would no doubt fully provide relief, is the apparent difficulty which different writers on this subject feel in endeavouring to express their thoughts and ideas in terms common to themselves and others. Thus, while everyone is striving to separate those conditions in which there is loss of power of articulating words from those in which a person cannot understand what he reads or what he hears spoken to him, and while everyone is familiar with the distinctive denomination of these two utterly different states made by Dr. Bastian as aphasia and amnesia respectively, it is not a little discouraging to find that every possible defect in language, including writing, &c., &c., is grouped by Dr. Bernard under the term aphasia. Indeed he actually gives at the end of his book a list of fourteen conclusions, the first of which runs:—"L'aphasie est l'amnésie des signes." This state of things is due, no doubt, to the religious reverence with which the opinions of Trousseau are still regarded in France, and because, unfortunately, Charcot has promulgated the following definition of the word aphasia:—"Le terme aphasie considéré dans son acception la plus large comprend toutes les modifications si variées, si subtiles parfois que peut présenter dans l'état pathologique, la faculté que possède l'homme d'exprimer sa pensée par des signes (*facultas signatrix* de Kant)."

Dr. Bernard admits that the French school of neurologists do not care in the least for the etymology of the words they employ in classifying these conditions, and hence they adopt a term which means inability to speak when they wish to express all sorts of conditions, among which is inability to understand what is heard; to put it in another way, they group distinction of motor and sensory function under the same heading. Surely a terminology based on such principles cannot but remain a stumbling block to the end of the chapter, just as in a converse way great confusion was caused for fifty years by Lænnec's use of the word tubercle. The temptation to acquire a general term has often led to the indiscriminate application of the same term to conditions

quite dissimilar, but we may hope that the actual difference in anatomical position of the functions of speech, writing, hearing, &c., will prevent such an unnatural grouping together as the use of the word aphasia proposed by the French authorities would entail. It would be foreign to our purpose to enter here on this question at greater length, but the attention of neurologists, which has already been aroused by Kussmaul's somewhat clumsy terms word-deafness, word-blindness, &c., cannot be too frequently directed to the confusion which is necessarily produced in the way we have just indicated. Dr. Bernard has produced an able summary of cases bearing upon all forms of disturbance of the "*facultas signatrix*," and more than that, has placed in a clear light the real position of the claims to priority of the various pioneers in this most deeply interesting subject. He shows in the most convincing way that the utmost credit which can be assigned to M. Marc Dax is that he localised the memory of words in the left hemisphere. In a few picturesque sentences he also tells us how Trousseau failed to appreciate Broca's splendid observation, and indeed how on one occasion that after Trousseau had demonstrated to the class the absence in one case of the now classical lesion, Broca took the specimen and showed that Trousseau's want of knowledge of the topography of the brain had led him into error, the case being particularly illustrative of the exactness of Broca's discovery. We might quote largely from the pages of historical references which Dr. Bernard gives us relating to the development of the theories of aphasia in France, but space will only admit of our taking up some of the most salient points of the clinical aspect of his work. Among confirmatory facts in favour of Broca's localisation he partly supports the observation, first made, we believe, by Rüdinger, viz., that in congenital deaf-mutism the left third frontal convolution is atrophic and less complicated even than the right. From photographs which the writer of this review possesses, this condition of things is seen to be by no means invariable, for in the instance now quoted the left third frontal gyrus appears quite normal, especially when compared with the right. Indeed it is scarcely conceivable, unless some distinctive change occurred early in intra-uterine life, that the speech convolution should not fully develop macroscopically even in cases where it never functionalises, since the outline given it by heredity would surely tend to be reproduced. Cases of non-development of motor convolutions when intra-uterine amputation

or injury of the limbs occurs, are not parallel, since in the case of deaf-mutism there is not necessarily any interference with the movement of the tongue muscles. Very little space is devoted to the details of the loss of the various parts of speech, or again, the loss of portions of words, and the reversing the spelling of the same, all conditions which, in a mild degree, may be met with in a person who has an intact brain but now is a little below par. A few very thoroughly investigated cases of this kind would place one topographical localisation of the various parts of speech on a very safe footing. It seems to us probable that each group of words has its own special home in the convolution, and that the synthetic arrangement into sentences is performed by higher centres in the intellectual and reasoning portions of the cortex. Attention may here be directed to the promising field of study of derangement of symbolisation which the alteration in power of executing mathematical problems affords, since in this case we have a pure instance of a word being represented, one might say, in a cosmopolitan and unalterable fashion. In one instance known to us of traumatic aphasia coupled with slight amnesia the mode of gradual recovery of the more complicated mathematical processes was very striking.

Dr. Bernard does not forget to give a very useful chapter on the medico-legal aspect of the aphasic and amnesic state. In it he adduces cases to show that we must always be guided in our estimate of the loss of individuality which such a patient has suffered by evidence on two points: (1) The amount of amnesia present, and (2) the amount of destruction which the left hemisphere has undergone. For while both hemispheres habitually act in concert to perform the same intellectual act or thought, still the massive destruction of one leaves the person so mentally reduced as to deprive him of many socio-political rights. On the whole we must congratulate Dr. Bernard on having produced a work which places the subject in its French dress so very clearly before us, and at the same time we must express our regret that even at the present time there is no international consonance of opinion as to the proper terminology of the various conditions which are commonly brought together under the title aphasia.

Blue Book: Reports from her Majesty's Representatives at European Courts and in the United States on the Working of the Lunacy Laws in the Countries in which they reside.
March, 1885.

These reports have been made in response to a Foreign Office Circular, sent out in August last by Earl Granville. The information required was specially in reference to these points:—

1. Whether there exist private as well as public asylums? If there are private asylums, whether they are subject to any special regulations as to the obtaining licenses, the class of persons by whom they may be kept, or of the persons who may be detained in them; or otherwise?

2. What checks, if any, are provided to guard against improper admission or detention of persons in such asylum?

3. What supervision and inspection, if any, are exercised by any public and recognised authority over (1st) private and (2nd) public asylums?

4. What are the nature and powers of such authority?

A heterogeneous mass of information has been collected by the Secretaries of these Legations, as might have been expected of men who have no special knowledge of the subject, and who were compelled on the spur of the moment to render such account of the management of the insane as they could obtain. We should have had a very different report to deal with had the Government deputed an expert to make these inquiries and to give a bewildered Parliament some clue to the unravelling of the intricacies of so various procedures in matters of lunacy. As it is, we have a book presenting all the disadvantages of its multiplex genesis, with no adequate analysis of it as a whole. We have lost an opportunity of securing such a book as the very excellent report of Dr. Norton Manning, published by the New South Wales Government, which labours under the disadvantage of being seventeen years old.

The Blue Book now to hand deals with thirteen countries, and in four of these the Lunacy Laws vary with the locality. There is nothing to be learnt from the laws of such States as Russia, Spain, and Portugal—except, indeed, it be what we should sedulously avoid, and it is difficult to understand why it should be thought necessary to request information from such unlikely sources, but for that reason. For instance, in

Russia it is thought necessary to enact that "It is strictly forbidden to keep sentinels in mad-houses, either in the rooms occupied by the lunatics, or outside in the yard, gardens, or grounds where they are allowed to walk," and further that "the authorities shall select a separate isolated house of considerable dimensions and walled in all round to prevent escape, when forming an establishment for lunatics." These humane laws are for the "Public Protection," as revised in 1876. The report on Spain enters at length into the history of the insane in that kingdom, and, as might be expected, there is more to be proud of in regard to the establishment of lunatic asylums in the fifteenth century than the present defective state of matters, for "Lunacy Laws can hardly be said to exist."

There seems to be fairly good provision for the proper treatment of the insane in seven European countries, and exceptionally good laws in Austria and Italy. The report states that the laws in these last-named kingdoms are satisfactory; but in Denmark, France, and Switzerland dissatisfaction exists: in Denmark, because no lunacy laws have been enacted, not because the present regulations are not working well; in Switzerland because the laws vary with the cantons, inclining to French or German ideas with the locality; and in France because there is no proper provision for criminal lunatics, nor for the management of the property of the insane, nor for the accommodation of paupers in State asylums, and other minor points. That is to say, the law being highly elaborated in France, minor matters are subjects of complaints that are not heard of in less fidgety countries. In France, Prussia, and Switzerland procedure in regard to the admission of patients is far too much an affair of the police, so much so that Switzerland gets credit in the report for the impossibility of undue detention on the score of the "systematic interference of the State with individual action," or what in non-official circles is irreverently termed *grandmotherly legislation*.

From the United States a detailed account of the regulations of the different States is sent, and conclusions are drawn which will prove rather startling to the readers of Dr. Hack Tuke's paper in the April number of this Journal, in which he reviewed the present condition of the insane in the States and effectually showed the worst side of judge and jury interference. Our Blue Book *per contra* invites us to admire the "management and classification of the insane

and the elaboration of checks on abuses which seem to have been carried to the highest point in *Illinois*."

On analysing the returns from Austria, Denmark, France, Prussia, Italy, the Netherlands,* Portugal, Russia, Spain, Sweden, Norway, the Cantons of Switzerland, and the United States of America, which constitute this Blue Book, we find that private asylums exist in all except Portugal. The reason given for this exception is that they would not pay in that kingdom. But a varying definition is given of the term *Private Asylum*—for instance, in Italy and Geneva it is held that the reception of one patient of unsound mind constitutes the house "private asylum, whereas in the Netherlands such houses are not so styled, and in Sweden five patients must be in residence to bring the establishment under this category. Waiving these details, and assuming a private asylum to be a house into which lunatics are received for pecuniary profit to the proprietors, we find that in general these places are licensed by the State authorities on the proof of proper care and treatment. This proof consists of the production of plans and particulars regarding the building, and certificates regarding the competency of the management. In Austria, France, Italy, Norway and Sweden the person in charge must be a duly qualified medical man. In Denmark and the United States generally, no license is required; and in Spain it is not compulsory, although in fact all are licensed, perhaps because such applications are never refused by the Provincial Committees for Benevolent Institutions under whose inspection they are placed by the laws.

The licenses of private asylums are made dependent on the proper conduct of the establishment in every country where the laws are definite.

In most countries the public asylums are more numerous than the private, but in Prussia the numbers are 36 of the former to 81 of the latter. The report does not give full details on this point, nor does it give the number of patients under treatment in each class, nor does it make clear if State-assisted lunatics are received into private asylums.

The checks provided to guard against improper admission or detention vary widely in detail. In every European country a medical certificate of insanity is required. This certificate may be granted by any competent medical man in Denmark, France, Prussia, Italy, the Netherlands, Portugal,

* There is no information from Belgium. A considerate Government probably thinks that we have had enough of Ghent.

Spain, Russia, Sweden, and Switzerland. In Austria it is granted by an official medical examiner, or if granted by the family doctor, it is certified by him; and in Norway it becomes the duty of the asylum-physician to examine and certify before admission, while an appeal may be made against his decision to the Special Committee of Control under which the asylum is placed. This Committee consists of three members nominated by the Government, one of whom at least must be a duly qualified medical practitioner.

These medical certificates are in most countries subject to the revisal of the courts of justice, but in Denmark such procedure is deemed unnecessary. In France a lunatic may be admitted by order of the police, if dangerous; or may be placed in an asylum on petition, medical certificate, and certificate of identity being produced. The Superintendent furnishes a report to the Prefect within 24 hours, and another within 15 days. The Prefect sends an expert to examine, and reports the result to the Procureur. In Prussia the procedure is complicated by regulations varying with the district, but no patient is there admitted to an asylum except on a petition presented by the police, and supported by medical evidence. This evidence, as might be expected, is rather fine drawn out. There are nine questions to be answered, and the last is to this effect: "On what grounds is the patient's admission into the asylum asked for? Because of being presumably curable? If so, on what grounds is this opinion held? Or in cases of presumptive incurability, because of the patient being quite helpless, or as being dangerous to the community? On what grounds are these opinions held, and are there no means of treating the patient in his own home?" Magisterial interference in the worst degree obtains in Portugal, where the medical certifier must examine in the presence of a judge and witnesses; in a lesser measure in the Netherlands, where the judge may examine patient and petitioner; in Russia, where the judicial examination is carried out in the patient's house or in court according to rank; in Geneva, where the interview with the chief of the police may be dispensed with only on the written recommendation of a doctor of the faculty of Geneva or other recognised officer of health. The regulations of the national asylum of Spain require a judicial sentence declaratory of the patient's insanity, a legalised certificate of his baptism or description on the civil register. On the receipt of those documents the order for the lunatic's conveyance to the asylum is issued. The judicial sentence

implies the declaration of the patient's incapacity by the judge, and the sworn declaration of his family of the necessity of his confinement.

In nearly every country special facilities are given for the immediate admission of urgent cases—in Austria, France, Denmark, Italy, the Netherlands (by order of the Burgo-master), Russia, Spain, Italy, Portugal, and in Prussia (but in the last-named only if dangerous to the community).

The checks provided to guard against improper detention are interwoven with the whole system of these laws. Registers and returns, reports and inspections, are the precautionary measures taken by the various Governments against wrong-doing. It is enacted that no person may be detained after recovery, and facilities are given in each country from which these returns have been received to such persons to consult the inspectors at their visits. In Italy and Russia the formalities attending the discharge of a patient are precisely the same as those on which he was admitted, and in the Netherlands also a medical certificate of recovery is compulsory. In Austria, Portugal, and Switzerland, the relatives or friends of patients may demand their discharge, although unrecovered, on giving a reciprocal bond to the manager of the asylum. In France and Switzerland they may appeal to the Tribunals for an order for release; the patient himself may also petition the Tribunals in France.

But the chief safeguard is evidently the periodical inspection of asylums by Government officials. In France the private asylums are visited every three months, and the public institutions every six months, but in the other countries (seven) which have given returns as to the periodicity of the inspections there is no difference made between the two classes of institutions.

The Official Sanitary Authority or Board of Health inspects in Austria, Denmark, and Prussia; the Courts of Justice officials in France and the Netherlands; and various Government authorities in France, Italy, Netherlands, Russia, Spain, Sweden, Norway, and Switzerland. In France the Special Visitors consist of the Prefect, the President of the Local Tribunal, the Procureur of the Republic, the Judge de la Paix, and the Mayor of the Commune. This is just that excess of officialism that might be expected of a country where every social change is considered to be a matter for the investigation of the police. In Italy the in-

spectors are appointed by the Prefects, in the Netherlands by the King. In Russia, Spain, and Portugal, the duty is delegated to the over-worked Governor of the District.

In Austria, the Netherlands, and France, the visits of inspection are made at uncertain intervals of not more than three months, and in Denmark the visits are made at least once a year.

The powers entrusted to these authorities are of the most ample kind, but the evidence on which action is taken is more medical than legal, and the Ministry of the Interior is usually supreme.

It is extremely doubtful if England has much to learn from these reports, unqualified as they are by competent medical skill, and without discounting for the differing social conditions of the countries. It is notorious that the German element in Manchester has lowered the tone of commercial morality in that city, and any attempt to Germanize our Lunacy Laws by making them, as in Prussia, an affair of the police, would in effect lower the tone of these regulations, and needlessly degrade and wound those whose duty it is to put them in action.

There are certain twigs of the foreign laws that would bear transplanting—for instance, in Austria persons suspected of being insane must be sent to the observation department of a public hospital to be there examined, and if found insane, must be at once sent to one of the public asylums. Again, in Italy, the notification of mental disease by the doctors and nearest relatives is insisted on, under penalty not exceeding 40*l*. But what would be said of a proposal to adopt the Swedish plan of the parson of the parish reporting on the lunatics of his district, or the asylum chaplain notifying the deaths of the patients?

A. R. U.

Hospital Construction and Management. By FREDERIC J. MOUAT, M.D., F.R.C.S., Local Government Inspector, &c., and H. SAXON SNELL, Fellow of the Royal Institute of British Architects, &c. 280 pp. London: J. and A. Churchill. 1884.

This valuable work ought to be in the hands of all who are interested in the construction of hospitals, whether general or lunatic, and will no doubt find a place in all our public libraries. The plates are numerous, and must have

been costly. Their value will be appreciated by everyone accustomed to consult works of this description. Such a book was wanted, and must remain a standard work until superseded by a still more laborious composition, which is not likely to happen for years. We hope to give in a future number an analysis of the subjects treated of, and in the meantime commend it to the attention of our readers, most of whom are immediately interested in hospital construction.

Vico. By ROBERT FLINT, Professor in the University of Edinburgh, &c. William Blackwood and Sons, Edinburgh and London. 1884.

This is the latest addition to the admirable series issued by Messrs. Blackwood, which we have already repeatedly spoken of in terms of approval. Some of the biographies may be of more interest than others, but all are ably prepared by authors thoroughly well acquainted with the subjects of which they treat, and able to present in a clear and condensed form what the reader wishes to know. The following volumes have been published:—Descartes, Butler, Berkeley, Fichte, Kant, Hamilton, Hegel, and Leibnitz.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

By T. W. McDOWALL, M.D., Morpeth.

Les Annales Médico-Psychologiques, from March to November, 1881.

Is there Albumen in the Urine of Epileptics? By Dr. J. Christian.

This paper contains no original observations, but is useful, if for no other reason, in directing attention to the absolutely irreconcilable results obtained by various observers. Special notice is devoted to the method of Dr. Klengden, who published a memoir in the "*Archiv. f. Psychiatric*," Band xi., Heft 2; but as a notice of this paper will be included in the Retrospect of German psychological literature, it is unnecessary to reproduce either his mode of analysis or his results. It may be remarked, in passing, that the detection of minute quantities of albumen in urine has received much attention of late in England, and that a decided advance has been achieved by Dr. Johnson by the

employment of picric acid. We would therefore venture to suggest this subject to the notice of asylum physicians, especially the juniors. Although the subject is of little practical importance, it is not to our credit that our knowledge of it should be so uncertain. If Dr. Johnson's method is what it professes to be, there should be no difficulty in settling the question at once.

Epileptics : Their Treatment and Care. By Dr. Lunier.

As it is undoubtedly true that a large percentage of epileptics are insane and the majority are at intervals dangerous to themselves and others, it is a question worthy some consideration whether the State is not bound to exercise some further supervision over them than exists in all countries. Dr. Lunier is of opinion that they require increased care by the State; but before considering exactly what is needed and how it is to be exercised, he attempts to ascertain how many epileptics and epileptic lunatics there are in France.

During the quinquennial period 1873-1877, 1,458,740 men were examined for the conscription; of these 2,398 were declared to be affected with epilepsy. This gives the proportion of 16.44 in 10,000 inhabitants; and for the whole of France 59,353 epileptics. But this method of calculation is quite erroneous, for the figures apply to men alone between 20 and 21 years of age. Before these figures can be used as a basis of calculation, we must first ascertain whether epilepsy is more or less common in men than women; and also whether the disease is equally common in all periods of life.

Dr. Lunier first attempts to settle the question of the relative frequency of epilepsy in men and women. On the 1st of January, 1878, there were 3,547 epileptic lunatics in the asylums of France; of these 1,887 were men, *i.e.*, 53 per cent., and only 1,660 women, *i.e.*, 47 per cent. But the proportion is quite different when the calculation is based on the number of non-lunatic epileptics who are only in hospitals. The proportion is then only 41 men to 59 women, but then it must be remembered that amongst the latter are a certain number of hysterics or hystero-epileptics. On combining the two classes of epileptics, lunatic and non-lunatic, the proportion of men is 50.23 to 49.77 women; that is to say, equality.

On comparing the figures obtained in five departments, Dr. Lunier found that of a total of 953 epileptics, 525 were men and 428 were women; that is, 55.09 to 44.9. These figures would indicate that epilepsy is more common in men than women—a result differing from that of some former observers, as Frank, Esquirol, Georget, Herpin, Delasiauve.

Epilepsy is not equally common in the various periods of life. It is relatively seldom seen in children up to six years of age, increases in frequency from six to twenty, and then diminishes. The majority of epileptics die young, and the new cases in persons aged more than twenty-one years are, as we remove from that age, more and more in-

sufficient to fill up the gaps produced by death, and more rarely by recovery. It cannot be doubted that if we tabulated epileptics according to age, beginning at twenty-one, we would obtain results more and more removed from those deduced from the examination of conscripts, who are men from twenty to twenty-one, exactly the age when the frequency of epilepsy is at its maximum.

Dr. Lunier accordingly concludes that in the population between ten and forty years of age there are 16.44 epileptics in every 10,000, or 14,350 men and 28,700 of both sexes. But this total should be further increased, for two reasons. It is well known that, in examining conscripts, only those are considered as true epileptics in whom the disease is undoubted, and that a certain number are declared fit for service although they are affected by simple vertigo or very rare epileptic attacks. Secondly, in the examination of conscripts, every person who does not present himself because he is detained in an asylum is considered a lunatic, though he may also be an epileptic.

Taking these and other figures into consideration, the proportion for the whole of France is 9.203 in 10,000 inhabitants, which corresponds to a total of 33,225. Of this large number, only 3,550, *i.e.*, a ninth, are in asylums; and it is estimated that 1,650 simple epileptics are in various hospitals. It follows that about 28,000 are in private dwellings.

Dr. Lunier proceeds to give information as to the manner in which epileptics in various countries are supervised. It would appear that unless they are lunatics they are not specially looked after. He is of opinion that in France alone there are 10,000 epileptics who should be removed from home care and placed in institutions. He does not give his grounds for this proposal, neither does he venture to suggest what kind of institutions should be prepared to receive this army of helpless and comparatively harmless people, although he thinks they should be erected in the neighbourhood of asylums.

Limited Responsibility. By Dr. A. Giraud.

This paper is simply a collection of some recent and ancient cases having this common character—that mental feebleness, congenital or acquired, was pleaded in extenuation of crimes committed. The cases are well recorded, and exceedingly interesting; but they do not disclose any new feature. Besides, to be of any use to the student, they must be read in full; an abstract would be of no practical value.

Chronicle.

It may be noted that a new feature in this Journal is an abstract of current psychological literature. It is not in the usual form of an abstract, in which paper by paper is reduced to the smallest compass, but it is a readable article in which a number of subjects more or less related are passed in review.

Consciousness in Mental Disease. By Dr. Dagonet.

Although this paper does not contain any original observations, or any new explanations of the wonderful phenomena as affecting consciousness and memory, observed in nervous disease, it is exceedingly interesting, and includes many observations and cases recorded by well-known writers, such as Littré, Despine, Luys, Maudsley, Ireland, and others.

Consciousness may be defined as that inner, immediate, constant feeling of the activity of the ego in all the phenomena of moral and intellectual life. From a religious point of view, we call the feeling of offences committed conscience; this latter is evidently dependent on the former; it is a part of it.

The philosophic aspect of consciousness is not dealt with fully; perhaps this is an advantage to the reader, for it is not yet profitable to follow an author who discusses the seat of consciousness, and who attempts to locate a special function in each separate layer of the cerebral cortex. Dr. Dagonet views his subject chiefly from a medico-legal point of view, and necessarily devotes much attention to the mental condition of epileptics, hystero-epileptics, and such like. It may be remarked, in passing, that the mental condition of criminals in France appears to be much more frequently the subject of investigation than in England. This is probably due to the mode in which the prosecution is conducted.

It is unnecessary to epitomise what refers to the states of consciousness in epileptics; this is a subject perfectly familiar to all physicians, but we shall pick out such paragraphs as relate to the changes in consciousness in lunatics—a subject not nearly so carefully examined as it should be.

In the different forms of mental disease the disorders of consciousness are in relation with those which attack the other faculties. This is a general rule which has few exceptions; but there are remarkable and exceptional cases in which cerebral automatism exists along with complete preservation of consciousness. The patient is an astonished, helpless, and sometimes frightened spectator of the disorder of his faculties, and begs protection against his violent impulses, feeling himself incapable of resistance.

The maniac preserves a more or less complete recollection of the unreasonable actions which he has committed under the influence of his delirium, and this recollection is the more precise in proportion as the period of convalescence is prolonged. Although memory is preserved, consciousness is lost at some moment or other. The patient is soon unable to fix his attention, his ideas escape without order or connection, there is a flow of incoherent words, sometimes really a torrent of ideas which nothing can stop, which does not give him time to find words to express them, and, as he says, he could not explain what was going on. Thus self-perception, if not entirely abolished, is in such cases extremely confused.

We may, in a way, admit in regard to anomalies of consciousness in the insane, two contrary tendencies which give a particular impress to character of the delirium ; one is passive, the other active.

In the former, the patient perceives impressions ; the sensations resulting therefrom are more or less obscure, and give rise to no form of reaction. In the active state the over-excited mind goes in a measure in advance of objects ; attention is on the stretch ; the faculties highly stimulated towards delirium, take an unusual development in this unfortunate direction. In both conditions sensations are imperfectly perceived ; they arrive at consciousness in an inadequate manner, they are interpreted incorrectly, and are the source of the strangest illusions. The reaction produced in the motor centres is no longer related to the impression perceived ; and in this case the manifestation of the faculties becomes unconscious.

Hallucination generally deprives an individual of self-consciousness ; it makes him, in a measure, passive ; he is its helpless victim.

If he sometimes seeks to understand the singular dominion under whose influence he finds himself, he yet allows himself to be blindly led by it, and under its inspiration we find him committing the most unreasonable actions.

In the insane the feeling of the personality sometimes suffers a profound transformation. Consciousness no longer perceives in the same manner the impressions which the external world can transmit to them ; objects assume alone an essentially altered signification : we can easily understand the consequences. This is observed in certain forms of lypemania, hypochondriasis, demonomania, zoanthropia, lycanthropia. In all such cases the persons are under the influence of disorders of the general sensibility. The transformation is complete, the individual has become another person, his impressions are different, he laughs at persons and things he formerly respected.

In cases of monomania of persecution, it is equally impossible to convince the sufferer of the falseness of his delusions. Total loss of consciousness is not always present, for we occasionally see patients retain an exact conception of their condition in spite of their disorders of general sensibility and of their hallucinations.

In chronic mental affections, as in those associated with paralysis and tendency to dementia, consciousness is obscured and weakened like the other faculties.

As has been shown, loss of consciousness is observed under the most varied conditions ; on the other hand, observation proves that this faculty may be maintained and manifested under the influence of certain neuroses, and in some varieties of mental disease. The person may have an exact perception of his diseased state, of his strange sensations, of the hallucinations, violent impulses, and fixed ideas which control him. Psychical life in such cases appears to be but partially affected. This condition has sometimes been described as "*double mental life*," or "*double consciousness*."

The concluding paragraphs are devoted to a review of the medico-legal aspects of the modifications of consciousness, but this is a subject so familiar to all alienists that it need not be further noticed here.

Ambitious Delirium in Local Organic Affections of the Brain and in Diseases of the Spinal Cord. By Dr. Baillarger.

It sometimes happens in patients affected with local lesions of the brain, or with diseases of the cord, that the grandiose delirium as seen in primary general paralysis, may last several months, a year, and even more, without the lesions of chronic periencephalitis being found post-mortem. This grandiose delirium, sometimes preceded by attacks of cerebral congestion, accompanied by motor lesions due to local cerebral changes or to diseases of the cord, leads to the diagnosis of general paralysis, a conclusion proved to be incorrect by the autopsy. Such cases raise interesting questions of pathological physiology.

Dr. Baillarger reproduces six such cases, recorded at different times by various authors. Using these as a basis for his remarks, he tries to explain how it is that we occasionally see patients labouring under organic brain disease, and presenting the mental symptoms of general paralysis, and yet we fail to find the characteristic lesion of that disease.

It may be suggested that the patients died in the first stage, and before the distinctive lesion was developed. This explanation is not sufficient. The local lesions which preceded the delirium can only have been its indirect cause: "they gave rise to an irritation and probably to fluxionary movements, which, as a consequence, led to a disturbance of the nervous elements, of which the delirium was the expression." It must, however, be remembered that such local cerebral lesions often give rise to mental symptoms of totally different characters. Calmeil has insisted on this point. How there should be such variety in the mental symptoms is a mystery, and M. Baillarger thinks it will remain so.

There appears to be an undoubted and intimate relation between cerebral congestion and exalted delirium. They are occasionally associated in diseases other than general paralysis, *e.g.*, epilepsy, alcoholic intoxication, and especially in the aged threatened by apoplexy or softening. M. Foville, in a case of general paralysis, where he failed to discover the characteristic lesion, explained the delirium by a state of congestion.

These facts are of importance in explaining the occurrence of the *remissions*, so well known, so important, but so mysterious. It is a matter of every-day observation that each attack of grandiose excitement is followed by an increasing degree of dementia. M. Baillarger therefore asks, "How difficult it is to understand this disassociation of the delirium and the dementia, if the two orders of symptoms are the expression of the same order of lesions! How simple, on the contrary, if we consider the mania a complication only ;

the lesions found after death only the indirect cause, and that, once produced, the excitement has an independent existence."

Bayle attributed general paralysis to chronic meningitis. He explained the grandiose delirium by the irritation which the inflammation of the arachnoid communicates to the cortex. Esquirol combated this opinion.

What then can we conclude from an examination of the whole subject?

We have to deal with two orders of symptoms, due to different direct causes.

On the one hand, *paralytic dementia*, which we frequently see run through all its phases without being accompanied by delirium, and which leaves after death specific and well-defined lesions.

On the other hand, the delirium of which the direct cause and the essential modality are unknown, but which, once produced, has an existence apart and an evolution of its own.

Note on the Employment of the Peptones of Meat in the Feeding of Sitiophobic Lunatics. By M. A. Lailler.

There appears to be no doubt that the peptones—these are the ultimate products of peptic digestion of albuminoid matters—are useful as foods in some cases. There are, however, difficulties in the way of using them. Those which can be bought are not reliable; to prepare them has hitherto involved much care and trouble.

The following method of preparation is recommended by M. Cotillon :—

"A kilogramme of beef, freed from fat and tendon and finely minced, is placed to digest at a temperature of 45° (Centigrade) for 12 hours with five litres of water acidified with 20 grammes of pure hydrochloric acid, and with pepsine in slight excess. The proportion of pepsine can only be determined by its activity. For example, we must use 35 grammes of pepsine (officinal), which digests 30 to 40 times its weight of fibrine (extractive pepsine is understood), or six grammes of pepsine, standard 200.

"The mixture must be shaken occasionally, and maintained at a constant temperature. Below 40° digestion is retarded; sensibly above 50° there is a risk of destroying the pepsine; on approaching 70° this is sure to happen. The mixture, at first like broth, gradually becomes fluid, and, after from two to six hours, according to the activity of the pepsine, becomes transparent. It then contains a mixture of peptones and syntonine; it is coagulated by heat and nitric acid.

"This dissolution must not be confounded with digestion. Very dilute hydrochloric acid can dissolve the albuminoids, but the solution presents the characters of proteine substances. It is the property of digestive ferments to cause them to lose this character and to change them into peptones.

"After twelve hours of digestion the insoluble parts are separated

by filtration. Rapid filtration shows that the transformation is pretty complete. The filtrate should not be boiled. A portion tested with nitric acid ought not to cause any cloud.

"The liquid should then be saturated with bicarbonate of soda and evaporated in a water bath. When concentration is fairly advanced, a slight skin forms on the surface, and the solution has arrived at the stage of saturation.

"It is best, for therapeutic use, to preserve the peptone in this state of syrupy solution. If evaporation is carried to dryness, its administration is not so easy, as it must be redissolved."

For feeding by the rectum the peptones should be prepared according to the process recommended by M. Bagros :—

"Lean beef	100 grammes.
Acidified pepsine, Boudault ...	4 "
Pure glycerine	20 "
Tepid water	80 "

"Grind the meat in a marble mortar till it is reduced to pulp; then add, in the order mentioned, the pepsine, the glycerine, and the tepid water. Place the mixture in a wide-mouthed flask or a water bath at a constant temperature of 40° to 45°. At the end of five or six hours the original rose colour of the mixture will be replaced by a grey one. Squeeze through a fine sieve. There will be eight to ten grammes of solid residue. The product is an opaque, grey, almost odourless fluid.

"The addition of glycerine, at the beginning of the operation, is indispensable to prevent the development of a disagreeable odour, and it does not in any way interfere with the solvent action of the pepsine. This preparation keeps perfectly for months without any special precautions to exclude air."

A Case of Somnambulism.

At a meeting of the French Society, M. Motet gave the details of the very interesting case of a man who was accused and convicted of an attempted immoral offence, already narrated in our Journal. M. Motet knew him to be a somnambulist, and accordingly interested himself in the man in his distress, and succeeded in getting the conviction quashed, not, however, until he had demonstrated an attack in the presence of the judge. From a medico-legal point of view, this case, as we have previously pointed out, is very important, and should be studied in detail by all interested in the legal and social relations of such people.

On the Increase in the Number of Cases of General Paralysis, and its Causes. By Dr. A. Sauze.

Although no new facts are brought forward in this paper, the various opinions which have been from time to time expressed are carefully considered and compared with Dr. Sauze's experience,

extending to some thirty years. He is very strong in attributing the increase of general paralysis to drinking, not occasional and excessive drunkenness, but that day-by-day imbibing of alcohol only too common in clubs and other social gatherings. Next to "nipping," he places the high pressure of modern times.

The paper is well worth perusal, though containing no original matter and not at all likely to convert any of the partisans who advocate so eagerly their own views concerning the cause of general paralysis.

Dr. Sauze's conclusions are as follows :—

1. General paralysis has increased considerably of late years.
2. In the south especially, where it was so rare that its existence was denied, general paralysis now affects a proportion very high and almost equal to what is observed in the north.
3. The principal causes of this increase are the abuse of alcoholic drinks, which has become general, and the abnormal brain-activity characteristic of our time. These two causes act in the same manner by producing cerebral congestion.
4. Then follow excessive coitus and the abuse of tobacco. Their action is only secondary in importance, but it is of the same nature as the preceding.
5. That these are the true causes of the increase of general paralysis is conclusively proved by the fact that women who are little exposed to them owing to the calm and regular life they enjoy in our social organization, are very rarely affected by this disease, and that the proportion has not increased recently. In those rare cases where it is observed in women, we always find the same causes which produce it in men.
6. This very remarkable change from functional insanity (the *vesaniæ*) to paralytic insanity is the pathological characteristic of our times, so far as mental diseases are concerned; exactly as in the middle ages there were the various forms of religious insanity, *demonomania*, *ecstasy*, &c.
7. It is to be feared that, under the influence of the same causes which do not tend to diminish, and by hereditary transmission, the proportion of general paralysis will continue to increase.

Investigations on the Use of an Exhilarating Mixture. By Dr. A. Adam.

Professor Lutton, of Rheims, having prescribed a mixture containing ergot and phosphate of soda in a case of subacute arthritis of the knee, found that it produced fits of laughter. Struck by this result, he gave the medicine to several persons, especially women, and observed the same results generally. Professor Lutton, therefore, presumes that it should be useful in cases of melancholia and hypochondriasis.

Dr. Adam administered it to several patients in the Fains Asylum, but the results were entirely negative.

Medico-legal Review. By Dr. A. Giraud.

This retrospect contains notices of many cases of great interest, especially illustrations of that most difficult of all medico-legal problems—limited responsibility. To make an abstract of an abstract is to waste work, and all we can do is to refer our readers to Dr. Giraud's paper, or, better still, to the original records. We are, however, tempted to make the following extract from a report by Dr. Penard. It contains words of true wisdom, which, if attended to, would save many scandals in criminal cases and much well-merited reproach heaped on so-called specialists in mental diseases. He says :—

“We accept too quickly and too freely those hereditary defects which we cannot accurately define; those arrests of development more easily pointed out in words than irrefutably demonstrated in fact; those masked affections which only occasionally drop their disguise; those organic asymmetries more often specious than real; indeed, whether the septum of the nose inclines a little more to the right than to the left, or to the left than to the right, is of no importance. That the left angle of the mouth is a little lower than the right; that the right or left eye is imperceptibly narrower or larger than its twin brother, matters not. These slight defects of form, from which we would have great difficulty in logically deducing pathological conclusions, nevertheless play a great rôle in extenuating circumstances.”

On the Co-Existence of Hysteria and Epilepsy in Both Sexes. By M. D'Olier.

This essay obtained the Esquirol Prize in 1881. As a contribution to the clinical investigation of nervous diseases it is of undoubted importance, but it is not of much practical value to students of mental diseases. It may, however, be consulted as containing details of several cases of genuine hysteria in males. It further confirms the opinions previously held, that the two diseases, hysteria and epilepsy, may co-exist in the same patient.

On the Relations of Insanity and Intermittent Fever. By Dr. H. Mabile.

Completely contradictory opinions have been expressed as to the connection between intermittent fevers and insanity. Sydenham pointed out a kind of mania consecutive to these fevers, especially quartan. But Grisolles remarks that his observations do not appear to have been confirmed by other physicians. Senac met with only one such case, and Baillarger with two. He accordingly thinks they were simple coincidences.

Boerhave and other German authors have indicated intermittents as occasionally giving rise to disturbances of the intelligence. Friedreich has collected a number of such cases. Baillarger thinks that these

fevers predispose to mental disease, by acting like all nervous diseases, but chiefly by producing anæmia, and, consequently, by still further augmenting the predominance of the nervous system over the blood system. He also believes that mental disease caused by prolonged intermittents frequently degenerates into "stupidité," and this because œdemas are amongst the most common symptoms of these fevers.

According to M. Christian, when the delirium is early, and when it occurs during, or in place of, an attack, cerebral congestion is marked.

In spite of his abundant opportunities, M. Dagonet never observed undoubted cases of intermittent fever passing into insanity. He is sceptical as to this ever occurring, and agrees with Guislain that the true cause is the cachexia and the impoverishment of the blood.

In the two cases recorded by Dr. Mabille, he believes that he can trace a distinct connection between the fever and the mental disease. In the first, violent delirium appeared during the fever and continued twelve days beyond it; in the second, excitement developed the day before the fever returned.

Medico-Legal Case—Murder, Monomania of Suspicion.

We take notice of this case, not to go through the symptoms, which are common enough, but to direct attention to the fact that the patient murdered the medical superintendent of the asylum where he was detained. The patient was well known to be a dangerous man; he had threatened violence over and over again, yet when admitted neither he nor his luggage was searched. He concealed a revolver and used it with lamentable effect.

Contributions to the Medical Jurisprudence of Lunatics. By Dr. Baume.

That the popular idea of a lunatic is entirely erroneous, need not cause us much surprise; but it is passing strange that judges, procurators, and other legal functionaries are almost as ignorant. They will not believe that a lunatic can reason, can prepare his plans, restrain himself and wait for the best chance—they consider such intelligence incompatible with the presence of insanity. But the experience of asylum physicians is entirely against the prejudices of the lawyers. Although many cases are on record to prove this, we cannot resist reproducing the following case—a really good example of what a lunatic can do in the way of self-restraint. The narrator is Dr. Baume, and we reproduce his story with very little curtailment:—

Twenty-three years ago I escorted the savant Malagute, dean of the Faculty of Science at Rennes, through the asylum at Guimper. He saw the lunatics at work, was present when they marched to the sound of the drum, and when they came into the dining-room and

arranged themselves nicely at the tables. Rather taken aback at what he saw, he said to me : " It is astonishing ; there is as much order as in a barrack, and yet all these people are in confinement because of insanity ! Where the insanity is I cannot make out ! "—" We do not limit ourselves," I replied, " to teaching them to march in file ; we sometimes prepare them for the bachelor's degree in science, and we find in France a faculty kind enough to receive them."—" Indeed, and which is that faculty ? "—" That which has for dean M. Malagute, at Rennes." The savant fixed his eyes on me as if asking whether his cicerone were an inmate of the asylum or not. " One can see," I said, " that you have no memory for faces ; for this is not the first time that I have had the honour of speaking to you."—" Indeed," he said ; " I have just been thinking on what occasion I saw you."—Two years ago, on the evening of the 5th December, 1855, I introduced an officer in undress to you. He was an inmate of the asylum, but I took very good care not to reveal to you his position or mine ; my only object was to give a little assurance to my patient by showing him that he might present himself in a drawing-room without being thrown out by the door or window, as his mental disease made him fear. You received him cordially !—" But I remember him quite well. That officer passed a brilliant examination, and was received unanimously. But surely he could not be mad ? "—" Not more than he is now ; we have just passed him."—" But it must have occurred during a prolonged lucid interval ? "—" So little prolonged, that during the journey he caused me serious uneasiness by his hallucinations ! He rambled in a pitiable way when he left me at the top of the stairs to undergo his oral examination. I was on tenter-hooks, and was only reassured when I heard his brilliant answers spoken with an animation and confidence of which I believed him incapable. When he returned I congratulated him warmly.—" Well, are you happy at last ? " " Am I happy ! I should rather think so. This will prove to these monsters if I am mad. I mean the devils with two paws who have for a long time poisoned my life ; have they not tried every instant during the examination to whisper nonsense into my ear ? But I was on my guard."

Thus before, during and after the examination, the patient was under the influence of delusions and hallucinations which, however, he was able to master so thoroughly that he concealed them from his examiners.

Archives de Neurologie. Revue des Maladies Nerveuses et Mentales, publiée sous la direction de M. Charcot.

L'Encéphale. Journal des Maladies Mentales et Nerveuses, sous la direction de MM. Ball et Luys.

Our space, unfortunately, does not allow of our giving an analysis of the articles which appear from number to number in these journals. We regret this, for papers are almost always of the most excellent

kind, full of clinical facts and of deductions therefrom. The amount of careful observation is very great, and the original character of the communications is sustained. The persevering application of morbid anatomy to mental and nervous diseases by our French *confrères* has been rewarded by valuable results, and many more may be expected.

2. German Retrospect.

By WILLIAM W. IRELAND, M.D.

Ueber Zwangsvorstellungen bei Nervenkranken von Professor v. Krafft-Ebing. Wien, 1884.

Ein Criminal-Psychologisch Denkwürdiger Gerichtsfall. Wien, 1884.

Zwei Fälle von Vieljähriger Verknennung Geistiger Krankheit (Verfolgungs-querulantenirrsinn) bei Sträflingen, mitgetheilt von Professor v. Krafft-Ebing.

Gerichtsärztliche Gutachten mitgetheilt von Professor v. Krafft-Ebing.

Die Geisteskranken Bevölkerungen im Grossherzogthum Oldenburg nach den Ergebnissen der Volkszählung vom 1 December, 1880.

Die Zählung der Epileptischen in Mecklenburg-Schwerin. Ib.

Dominant Ideas.—In the first of these contributions Professor Krafft-Ebing defines a *Zwangsvorstellung* as an impairment in the succession of ideas, so that a concrete idea takes possession of the mind with morbid intensity, and refuses to go away, remaining fixed in consciousness. The patient cannot dismiss the notion, although he does not exaggerate its importance. Such a dominant idea generally appears suddenly, and may occupy the mind for hours and even days, when it disappears perhaps to give place to another. The fixed idea generally is annoying or painful, sometimes prompting to words or actions of an immoral or disgusting character. The import of these dominant ideas is, in the manifold nature of our mental life, very various. Many patients have a feeling that they are losing their understanding, that their thinking power is deserting them. These generally suffer from neurasthenia cerebri; others are haunted by the fear of apoplexy or some form of sudden death. These patients are generally suffering from hysteria or neurasthenia with irritable heart. They experience a feeling of distress, oppression in the throat, and palpitations of the heart. Others are afraid to venture into closed rooms, fearing fire, or that the roof should fall in on them; some have a feeling of danger on the approach of storms; others receive persistent ideas at the sight of metals, poisons, or animals, or have a morbid horror at the contact of dirt.

The first of Krafft-Ebing's instances was a woman of 35, whose father had suffered from mental derangement and her mother from nervous affections. She was soon exhausted, easily fell asleep, and had sometimes a feeling of tightness in the head. She had been troubled with unquiet thoughts for three years, which deprived her of all rest. Five weeks after her confinement, when she was anæmic and had a feeling of exhaustion, some one spoke to her about mad dogs. During the night she awoke under the persistent idea that her husband might meet a furious dog which might bite him, and so destroy the happiness of her family. She could not get rid of this fearful notion, and was compelled to think out all the likelihood and consequences of such a possible misfortune. The most remote things and facts had for her an association, leading to her dominant idea. Under its influence she was afflicted with the greatest anxiety, despair, and disinclination to fulfil her household duties, everything becoming indifferent to her in the face of such a possible misfortune. In quieter hours she herself saw the folly of these thoughts, but could not persuade herself that such an event was not likely to happen. The dominant idea came abruptly, sometimes remaining for a day. For a week she would have rest, then if she read about a man who had been bitten by a dog, the idea returned with frightful intensity; sometimes the mere sight of a dog would bring it on. The house physician diagnosed disease of the imagination, another physician treated her for anæmia, and gave bromide of potassium, but without result. Dr. Krafft-Ebing prescribed

Valerianate of zinc	...	...	...	0·3 grammes.
Sulphate of quinine	...	...	...	0·5 "
Aqueous extract of opium	...	...	0·3	"

to be made into 60 pills, of which eight were taken daily. This was followed by some improvement, when she ceased to come to consult the learned physician.

Another instance given was that of a priest, 38 years of age, of temperate habits. In 1861 he was much distressed by the fear of cholera. For several years while celebrating the mass he has been seized with the idea that he is unworthy to perform so sacred an office. He has then a feeling of distress, palpitation, warmth in the head, with profuse perspiration, so that he can scarcely carry through the service. This sense of his own unworthiness, which, when given in smaller measure, our own preachers are apt to make a flourish about, the Austrian priest regards as a stupid fancy. He thinks that if he could take a glass of wine he would not be so troubled; but this, we suppose, the rules of the church forbid.

A common kind of dominant idea is the feeling that they are objects of attention to other people. Another of Dr. Krafft-Ebing's patients was haunted by profane thoughts while saying her prayers, and had sometimes a feeling that she had a stone instead of a heart.

He considers that these sudden dominant ideas are sometimes the cause of suicides and of homicides.

He cites the case of Katharina Olhaver. Her mother had puerperal insanity at her birth. She herself, when 21 years of age, had a still-born child. She was deeply grieved, and had one epileptic fit, which did not return. In the sixth week she took a child to nurse, and had a mother's care for it. In the thirty-second week the menses returned, after which her nursling ceased to thrive. One evening when she was alone with the child, she saw a knife lying on the table, when the thoughts came into her head to cut the child's throat with it. In horror she fled to the kitchen and asked the cook to stay with her, for she had such bad thoughts. The cook, however, went away and left her alone with the infant. In order to get rid of her fixed idea, she began to sing and to dance round the room with the child. She went to sleep with it, but awakened with the same horrid thoughts. The return of her mistress somewhat calmed her, when apparently the child was given to the mother. At three o'clock in the morning she waked the household complaining of illness and bad thoughts; and the day after she confessed their nature. The idea disappeared after some days. The child was still entrusted to her care, a fine proof of the phlegmatic philosophic German nature. She often caressed the child with tears, saying, "Did I wish to kill you, my little angel. How could the bad enemy put such a thought into my mind?" In the end the idea totally passed away.

Dr. Krafft-Ebing puts the question, Do these homicidal or suicidal ideas ever pass into action? He seems satisfied that he can make a distinction between the fixed ideas with which the balance of the mind is not overcome, and those in melancholia. As far as I can follow the author, it amounts to this: the subject of the dominant idea preserves reasonable relations with other people unaltered, whereas the melancholic is indifferent to everything but his own distress. In another place the professor recommends the patients not to be left alone, as it is possible that they might carry some of their ideas into action, and also because the presence of another person is a great relief to them.

Those who suffer from this form of derangement may be considered as all suffering from neurasthenia. They are hypochondriacs, hysterical, or epileptics. Naturally he recommends a tonic treatment, the patient to be much out of doors, and to try sea or mountain air, hydropathic treatment, rubbing, river or sea bathing, and general electrification. The medicines which he has found beneficial are quinine, ergotine, zinc, arsenic, the phosphates, and opium. Anæmia is to be treated with iron; where hysteria prevails he uses valerianate of zinc or bromide of zinc. For a hypnotic he recommends opio-quinine and paraldehyde. He thinks it not advisable to try to conquer the idea by accustoming the patient to the things of which he has a dread. This only aggravates the hyperæsthesia.

In the second paper Dr. Krafft-Ebing gives an account of a neurotic

family, three of whose members got within the grasp of the law for scattering anonymous papers about full of threats of murder and arson, and shameful accusations against different people in the neighbourhood.

After a good deal of mischief, the mother Kr, her daughter Josefa Kr, twenty-one years of age, and John Kr, fifteen years of age, and a young man called Senek, who had, at John Kr's instigation, accused some one of shooting at him, were arrested and accused of deceit and calumny. They were condemned and sentenced, the boy John Kr to eight months, the mother to six months, the daughter to four months' imprisonment, and Senek to a year's imprisonment. As the mental condition of John Kr excited attention, Dr. Krafft-Ebing was sent to examine him. He found him an ill-grown, cowardly, nervous boy, who took no interest in play, avoided companions, and could learn no work. He suffered from headache, and was easily wearied. The head was rather small and defective in its occipital development. The papers which he wrote were gross, stupid, obscene, and abusive productions. He evidently belonged to the class of people who deface public monuments and tombs, throw vitriol on women's dresses, get up ghost stories, write anonymous letters, and make false accusations against their neighbours; such people are at once cowardly and aggressive, lying and credulous. Their success in making mischief is a perpetual proof of the stupidity of human beings.

John Kr was not imbecile, having the wish to involve his mother and sister, who were also of a neurotic character, and the young man, Senek, in his silly plots and shallow devices. The Professor does not tell us how to get rid of such personalities.

Religious Melancholy.

Eliza S., 28 years of age, a married woman, tried to poison herself and her daughter, who was seven years of age, with arsenic which her husband had in the house. It caused her to vomit, and both she and the child recovered. The reason she gave was that the priest at confession had reproached her with her negligence to her religious duties, and some other delinquencies. While working in the fields the fixed idea came upon her that the devil would come to carry her away alive. She, to be beforehand with him, determined to take her own life and fall dead into the devil's arms. She determined to kill the little girl at the same time, because the devil would have no power over an innocent child, and she would go to heaven. Her husband said that she was in despair at the idea that she would never get to heaven, and tried to convince him that his fate would be no better. She imagined she saw a red cow running in the meadow, and was afraid of imaginary black dogs. Her little daughter said that her mother prayed before giving her the poison. On the report of Dr. Krafft-Ebing she was sent to an asylum.

The other reports are principally medico-legal cases of mania of persecution, which, if condensed, would lose their instructive features.

Census of the Insane in the Duchy of Oldenburg.

In a paper of 61 pages (*"Zeitschrift für Psychiatrie"* xl. Band, 4 Heft.), Dr. Kollmann analyses the statistics of the Duchy of Oldenburg, which consists of the State of that name on the German Ocean, the principality of Lübeck, and that of Birkenfeld on the Nahe, a stream which flows into the Rhine near Bingen. The whole Duchy has a population of 337,478. One advantage of the statistics of these small States is, that they are generally taken with more exactness than in larger communities. By way of comparison he introduces a number of valuable statistical tables from most countries in Europe. On the 1st December, 1880, the whole Duchy of Oldenburg contained 977 insane persons. There are no large towns, and the population is principally rural. The number of idiots and imbeciles was 357, and of insane 620, that is, there were out of every 100 lunatics 36·54 idiots,* and 63·46 insane in the whole population. In the several States the proportion was different; in Birkenfeld there were 66·29 idiots per cent., and 33·71 of the insane, while in Oldenburg the proportions stood as 33·50 and 66·50 insane. It was found that amongst the idiots there were 17 per cent. who were epileptic, and 12 per cent. epileptic amongst the insane.

By the census of 1871 there were in Prussia, out of a population of 24,643,623, as many as 33,740 idiots, and 21,303 insane; in all, 55,043. The statistics of the German census of 1880 are not yet given out in a mature state for comparison. The number of the insane returned in 1880 was 66,345, showing an increase of 11,302. Unfortunately he does not give the total population.

The following statistics of insanity are additions to our knowledge :—Austria (census of 1880), population 22,144,244; insane, 13,116; idiots, 32,413; total, 45,529. Hungary (1881), population, 15,738,468; insane, 12,809; idiots, 20,672; total, 33,481. Denmark (1870), population, 1,784,741; insane, 2,454; idiots, 1,430; total, 3,884. Norway (1865), population, 1,701,756; insane, 3,156; idiots, 2,039; total, 5,195. Italy (1871), population, 26,801,154; total insane, 44,102. Commenting upon his numerous statistical tables, Dr. Kollmann observes that insanity seems most frequent with peoples of Teutonic origin in Germany, in Norway, in the British Islands, but this does not hold good with Holland. He forgets that most of the people of Ireland, Wales, and three-fourths of Scotland are of Celtic origin. The following extracts from his tables will be read with interest.

* I have translated blödsinnig by the word idiotic. It may include some demented cases.

In the following countries there is—

England and Wales	...	1 insane person for every 574 inhabitants.	1 idiot 771	1 of either 329
Scotland	...	495	727	294
Ireland	...	554	803	328
Denmark	..	727	1248	460
Sweden	...	567	2554	464
Norway	...	539	835	328
Oldenburg	...	544	945	345
Prussia	...	1157	730	448
Austria	...	1688	683	486
Hungary	...	1129	761	470
Switzerland	...	—	—	344
Canton of Berne	...	392	335	181
Italy	...	—	—	608
France	...	683	1028	410
Belgium	...	748	2890	594
Holland	...	—	—	656
Bavaria	...	1022	659	401
Wirttemberg	...	465	482	237
Saxony	...	1178	729	450

To anyone who scans this table the diversities must be very striking. Why, for example, should there be such a great preponderance of idiots in Austria and Hungary, whereas in Sweden, Denmark, and Belgium there is such a preponderance of the insane? The most unhappy districts in Europe for insanity seem to be the Canton of Berne, where there is one person either insane or idiotic to every 181 inhabitants, and Schleswig-Holstein where there is one to every 268, while in the neighbouring kingdom of Denmark there is only one to every 460. Saxony has one person idiotic or insane to every 450 inhabitants, and Ireland one to every 328, yet suicide is twenty times as common in Saxony as in Ireland. The number of suicides in Ireland is 17 to the million; in Scotland, 34; in Italy, 38; in England and Wales, 69; in Norway, 72; in Belgium, 78; in Sweden, 91; in Bavaria, 100; in Austria, 130; in Prussia, 152; in France, 160; in Wirttemberg, 169; in Baden, 177; in Thuringia, 305; and in Saxony, 338. These figures refer to the years between 1874 and 1878. In Oldenburg he finds amongst the causes of suicide 27·80 per cent. owing to insanity; *tedium vite*, 23·82; and drunkenness, 16·22. In respect to the increase of insanity, Dr. Kollmann finds that in Oldenburg there was an increase from 1855 to 1871 of from 3·3 in the thousand to 3·47; but by the census of 1880, it was found that there was a diminution alike in the number of the idiots and the insane, both together being 2·89 in the thousand, which brought the proportion lower than in 1855. Notwithstanding this, and allowing for sources of error in the statistics, Dr. Kollman

agrees with Koch and Cettingen, who have made very laborious inquiries into the question, that it seems probable that there is a progressive increase in the number of the insane in most countries of Europe. His calculations that there are more men idiotic and more women insane, and that the insane are a much longer lived class than the idiotic, only confirms what is generally known; nor does it need a laborious inquiry to let us know that few idiots are married, though it is interesting to learn that any are married at all.

Census of Epileptics in Mecklenburg-Schwerin for 1882.

Dr. Tigges, in the same number of the "Zeitschrift," gives the results of an attempt to count the epileptics in this little State, with the view of gaining information as to the expediency of erecting a training school for children affected with this malady, to be connected with the school for imbecile children at Schwerin. The schedules were entrusted to the clergymen of the different parishes to get filled up. The number of epileptics was found to be nearly the same as the number of idiots, 639 of the former, and 658 of the latter. Taking an average for the town of Schwerin, from which they could not get trustworthy returns, it was estimated that in the Principality there was one epileptic to every 855 inhabitants. In a census of the Rhine Provinces, taken in 1881, it was found that there was one epileptic to every 1,177 inhabitants. Up to 21 years of age there is a greater number of male epileptics, after that of females. The females last longer under this disease, the average duration of epilepsy in males being found to be 13.1 years, and in females to be 15 years.

Amongst 639 epileptics, 167 = 25 per cent. were idiotic or insane; of epileptic children between six and fifteen years, 20 per cent. were weak in mind; of 639 epileptics, 430 were unmarried, 67 per cent.; out of 658 idiots, one was married and one was a widower.

3. *English Retrospect.*

Asylum Reports for 1883.

(Continued from page 127.)

Glasgow. Town's Hospital and Asylum.—So far as we can remember, this is the first occasion on which we have noticed this report, for the very good reason that we never saw a copy of it before. It is quite evident that Dr. Robertson possesses most exceptional opportunities for clinical and pathological observation. Relative to his asylum work, he makes a few sensible remarks. These are arranged under the following heads:—1. Individualisation of Cases. 2. Medicinal and other forms of Medical Treatment. 3. Diet and Clothing. 4. Occupation and Exercise. They need not be repro-

duced here, as they are familiar enough to all engaged in asylum management.

Glasgow. Gartnavel.—As an additional protection against the dangers of an outbreak of fire, the asylum is in direct communication with the central fire-office in Glasgow, and the wire is tested daily. Of the total admissions (147), no fewer than 129 were private patients. Although only 65 cases were discharged recovered, 40 more were sent home when well enough to return there. Many of these might, of course, with perfect justice be added to the list of recoveries.

Helensborough was chosen for summer quarters, and the change, as it always does, yielded both health and enjoyment.

Glasgow District Asylum.—The following paragraphs from Dr. Clark's report, relative to the boarding-out system, are important in that they contain *figures* besides opinions. One of the Commissioners in Lunacy points out in his report that, were it not for the system pursued, instead of an asylum containing 180 patients, one for 480 or 640 would be required. The average length of residence is between twelve and thirteen months—in other asylums it is more than three or even four years.

“Of the last (38 boarded-out cases) 25 were males and 13 females, and 10 being brought back, viz., 7 males and 3 females, the net result was 28. In view of so much that is being said for and against the disposal of harmless chronic patients in private dwellings, a review of our statistics and experience for the last three years will probably be found interesting. Eighty-two cases have been boarded-out, and eight received accommodation in lunatic wards of poor-houses—total 90, viz., 44 males and 46 females. Of these 12 males and 6 females required to be brought back to the asylum after an average residence outside of three months and eight days each. The net result is 72 in three years, which is equal to 13·3 per cent. of the total number of persons under treatment during that time.

“The financial advantage of boarding-out is only realized after prolonged residence in a private dwelling; and the nearer the allowance made to a guardian approximates to the rate charged in the asylum from which the patient has been removed, the less obvious does the advantage become. The first year of private residence is the most expensive, because the cost of removal from the asylum, and the extra outlay on account of first clothing, are special items. The usual Guardians' allowance is 7s. per week, clothing (which is furnished in addition) costs for the first year at the rate of 1s. 6d. to 1s. 9d. a week, the visiting medical officer receives from £1 to £1 10s. a-year, and these, added to inspector's expenses, bring up the cost for the first year to not less than 9s. a-week. If the asylum rate is 9s. 3d. a-week, it takes at least a seven months' residence in a private dwelling to pay expenses; and if at the end of nine months or less the patient requires to be brought back to the asylum, a distinct loss is in-

curred by the parish, because of the expenses incidental to a second removal and committal to asylum care. When the asylum rate is higher than 9s. 3d. the gain is reached earlier, and a stimulus to boarding-out is more likely to arise; but in all cases the financial gain steadily increases with the length of residence when the first year is over, if not sooner. So far as my experience of the subject goes, the mental gain to the patient is during the first year the more certain of the two; and I have frequently been gratified to observe that this consideration weighs more with inspectors of poor who have really studied the subject, and that financial gain has not been allowed to absorb their whole attention in the matter.

"A very important question in connection with this is that of relative guardians *versus* stranger guardians. The following figures will to some extent throw light on the matter:—34 were boarded-out with relatives, and 48 with strangers. Of the former, 11 were brought back to us, and of the latter 7, so that while 23 remained with relatives, 41 remained with strangers. In many cases the relatives were subsidized by the parochial board; but as a rule they failed in patience, tact, and tolerance, and evinced a want of moral and mental vigour which rendered them practically helpless with their afflicted relatives. To such there are notable and praiseworthy exceptions, but the rule is as has been stated."

Gloucester.—At the present time when additions are in progress in so many asylums, it may be of use if we reproduce the following paragraph relative to a new method of heating. Any improvement on the methods at present in use would be gladly welcomed, for they are ridiculously extravagant, wasteful, and troublesome.

"We have, therefore, had full experience of the practical value of the new system of Dowson's Gas, which we have introduced into the second asylum. Mr. Dowson himself confesses that never before has the opportunity been afforded him of testing the efficiency of his system over so large an area. A few difficulties have been met with in the practical application of this new system, but none that have not been overcome, and experience shows that the four generators for the production of the gas are capable of producing gas enough to heat the laundry boilers, for washing and bathing, to heat the drying-closet, to drive one engine, and to give a full supply for the kitchen, all which apparatus may require to be in action at the same time. We therefore consider that the Dowson's Gas supplied as above-mentioned is a success. We have not been able accurately to estimate the cost of the working of all apparatus, as a great deal of gas has been consumed in making various experiments, but we believe that it is a far more economical manner of using coal than the previous modes of heating that have been usually applied. An effort has also been made to apply this mode of heating to baking-ovens. Very encouraging reports had been received of experiments showing the economy and cleanliness of baking-ovens heated by gas, and a contract was entered into with

Messrs. Thompson, the originators of the patent, to erect two such ovens on our premises. We have tried to work these ovens for the last two months. The bread has been well-baked in them, but at a much greater cost than had been anticipated."

As an experiment, the laundry block is lighted by electricity—the first asylum in England, we believe, where this agent has been so used.

It is with great regret that we notice the difficulties which have arisen between Mr. Craddock and the Commissioners. We cannot attempt to go into the various matters in dispute, but we would like very much to see a record of the case of the man (a patient) who acted as porter. It seems to be admitted that he has been insane since 1859. In October, 1882, he was still insane, declaring himself to be Jesus Christ; and in December of the same year he was discharged recovered. Although the case-book containing the early history has been lost, that matters little; for Mr. Craddock and the other medical officers are, no doubt, able from memory to supply all that is interesting and necessary. After a man has been insane for at least 23 years, an account of his recovery, as given by himself and observed by others, would be of great interest, and would be welcomed as a contribution to the Journal.

Mr. Craddock is naturally much hurt at the severe censures made by the Commissioners as to the state of his asylum, and he has "accordingly added an appendix to this report containing extracts from the entries made by several Boards of Guardians in the county after visiting the asylum and seeing their patients." In giving such extracts he has, we think, committed a double error. All men connected with asylums know that the entries made by Guardians after making their visits are not worth the paper they are written on. It is impossible to oppose the expert opinions of the Commissioners with the entries made by a few farmers and such like—very decent people no doubt, but very possibly never in an asylum before, and no more capable of giving a reliable opinion on the state of such an institution than they are of criticising the management of Greenwich Observatory. Much to our surprise and regret, it appears to be rather the fashion now to give these ridiculous entries in the annual reports—a great mistake—for thereby too much importance is attached to these minutes.

We most sincerely wish Mr. Craddock a happy issue out of all his afflictions. His work must at present be peculiarly trying, for he has the charge of an old asylum and the building and organisation of a new one to attend to at the same time.

Hants.—New buildings, involving an expenditure of £12,695, have been completed and partially occupied. There is now accommodation for 1,000 patients. It is proposed to build cottages for married attendants. Dr. Manley is to be congratulated on the evidence of the value placed on his services by his Committee, when in office and since his regretted retirement from ill-health.

Hereford.—Dr. Chapman writes as follows :—" In the case of this asylum, there is a stronger tendency than in most others to send in patients suffering from various forms of decay, such as might be cared for in well-equipped union workhouses, and are largely so in the large workhouses of urban and manufacturing districts, with properly-appointed infirmaries, but which cannot apparently be satisfactorily treated in small country workhouses. This circumstance makes our average recoveries compare unfavourably with those of asylums which serve such districts—since these cases really afford no recoveries. I cannot divest myself also of a feeling that a cruelty and injustice is involved in treating as lunatics old people who suffer from little more than that failure which affects no small minority, perhaps a majority, of those who exceed the allotted three-score years and ten, and who otherwise have never suffered from any mental disorder."

With the latter sentence we can hardly agree. Far from its being cruel to send demented old people to a county asylum we consider it may be a great kindness. Should it ever be our lot to end our days in poverty and senile dementia, we can only pray that it may please the Fates that our last earthly home may be an asylum and not a workhouse. It may be an unwarrantable luxury, but not "cruelty."

Inverness.—To those interested in asylum-statistics this report will prove agreeable reading, as it contains a review of the admissions, &c., during 20 years—the time the asylum has been open.

Since the buildings were enlarged and more room given to the patients excitement has much decreased, and several chronic cases have so much improved that they have been sent to reside in private dwellings. Considerable difficulty seems to be experienced in obtaining suitable homes for such cases. The ventilation has been improved with most satisfactory results, but phthisis continues to be quite a scourge.

The changes amongst the attendants are remarkably numerous. In little over eight months 15 resigned and four were dismissed.

The statistical tables used are not those recommended by the Association. We are curious to know the reason.

Ipswich.—The report of the Commissioners contains the following: "One woman complained, 1st, that she, when she brought grievances to the notice of the Chairman of the Committee here with respect to matters which have occurred within this asylum, had been referred by him in writing to the Committee at Melton Asylum. It is true the patient is a Suffolk patient, but for grievances or complaints of matters within this asylum the Committee here are the persons to whom the patients naturally look for redress. The second complaint," &c. There can be no doubt that the patient was misdirected, and we can only wonder how a Chairman of Visitors made such a mistake. To prevent harshness and cruelty by nurses and attendants, it is most wholesome that they should know that any rational complaint will be thoroughly examined. Experience clearly proves that when there

are repeated complaints by several patients against one or more attendants in a ward there is something wrong, and the sooner the offenders are convicted and punished the better for the patients. Although nurses, as a rule, are seldom guilty of gross cruelty, they undoubtedly are occasionally harsh. When patients complain of having their arms twisted, the management of that ward is not what it should be.

Kent. Barming Heath.—Dr. Davies is again able to report that a post-mortem examination was made in the case of every death.

Kent. Chartham Downs.—The sum spent on amusements in this asylum seems to be unusually liberal. In 1882 no less than £110 was so spent. An allowance is made by the Committee, and it is augmented by the earnings of the patients during the hop-season.

Killarney.—The following paragraph from Dr. Woods' report shows how pauper lunatics are managed in Irish workhouses:—

"The decrease in the numbers was caused by the discharge, during the summer, of 16 harmless and quiet chronic patients to their workhouses in order somewhat to relieve the overcrowded state of the wards. One of these patients has since been sent back, being found too troublesome, and I am only surprised that the remainder have not returned also, no provision whatever being made in the workhouses of this county for the isolation and proper care of chronic lunatics and imbeciles, the majority of the Boards of Guardians believing they ought to be provided for in the asylum. I would find it hard to select any in the asylum at present fit to be drafted to the workhouse under existing arrangements. In only a few of the larger workhouses are there paid attendants, the unfortunate lunatics in the most of them being handed over to the tender mercies of the pauper inmates."

Dr. Woods again directs attention to the very objectionable mode in which most patients are committed to Irish asylums. The present arrangements are simply scandalous.

Lancashire. Prestwich.—The weekly charge has been raised from the very low one of 7s. 7d. to 8s. 9d. The annexe not being ready for occupation, it was necessary to refuse admission to all epileptic and advanced general paralytics.

An unusual death occurred from a patient eating lime. It had been spread on the turf to renovate the soil, and no rain having fallen to slake it, it proved an irritant poison.

Lancashire. Rainhill.—During 1883 the Commissioners have more than once directed special attention to the fact that patients have a right to converse with the magistrates during their visit of inspection. We agree with the following paragraph, for though many unreasonable demands may be made by patients, the magistrates are there to listen to what they have to say.

"Complaints were made by more than one male patient, that upon the subject of discharge they had no real opportunity of speaking with the members of the Committee periodically visiting the wards.

These complaints are probably exaggerated; but it is difficult to understand that they are absolutely groundless, and we trust that the attendants will not be allowed to interpose obstacles, however unfit for discharge the patients complaining may be. Freedom of speech in a respectful manner will content, or to a certain extent moderate, the discontent of many patients."

Amongst the admissions six were found "not insane." Of these, one man was suffering from pneumonia with exceptionally violent delirium, and his behaviour before admission certainly justified his removal to an asylum, as he had escaped from his sick bed on to the roof of an adjoining house, from which point of advantage he hurled slates against all who attempted to approach him. Both the delirium and its cause subsided immediately on his reception into the asylum, and Dr. Rogers remarks that the case is a good illustration of what he had often before insisted on—the necessity of a thorough medical examination of every patient on admission, so that any previous errors of diagnosis, if made, may be corrected.

Lancashire. Whittingham.—The new annexe has been completed, and is now occupied by 606 patients. We are very glad to notice that Dr. Wallis's salary has been raised to £1,000—a sum not by any means too large for the duties he has to perform.

In their report the Commissioners repeat their protest against asylum accommodation being used for cases suitable (in their opinion) for workhouses. They say—"We have lately visited the lunatic wards of several of the large union workhouses in Lancashire, and have been much struck by the large number of patients, many of whom had been for years in the workhouse, who have lately been sent to this asylum and to Lancaster. One hundred and seventeen patients have been admitted from workhouses since the last visit, and we are satisfied that over half that number, at the lowest computation, might well have been left in the workhouse, near their homes and amongst their friends. The cost of maintenance here is 8s. 2d. weekly; the 4s. grant reduces the charge to the ratepayers of the union to 4s. 2d. for each lunatic; but if the patients continue to be brought here in anything like the same proportion as has recently been done, the new annexe will be full, the asylum will be unable to receive recent and curable cases, and the necessity of building a fifth asylum for the county will have to be met."

Concerning teaching in asylums, the following paragraph from Dr. Wallis's report is of interest:—

"Though the records of the employment of patients show a gratifying increase in the numbers employed, yet there is a considerable number of male patients for whom no suitable work can be found. There is also an insufficiency of needlework to occupy the whole time of the female patients. Under these circumstances I have been led to the subject of school classes as a means of employment. My personal experience of them has been somewhat limited, though

bi-weekly classes were held in one of the asylums with which I was formerly connected. In order to obtain some further information in the matter, I recently visited the Richmond Asylum at Dublin, where school work is systematically carried out on a large scale. I was much interested in what I saw there, and am satisfied that much good to our patients would result from the establishment of educational classes of various grades, from the Kinder Garten object lessons upwards, as an adjunct to the existing modes of employment. I am persuaded that they would furnish a valuable portion of the discipline necessary for the curative treatment of the insane; furthering and hastening the recovery of curable cases, and promoting order and quietude, habits of industry and self-control amongst those who are unfortunately beyond the reach of recovery. I need not enter more fully at present into this matter; but I desire to record my conviction that good results may be expected from some well-organised work in this direction." Dr. Lalor's good example is, at last, telling.

Leicester (Borough).—The additional wing on the male side has been completed, and is now in use. The general arrangements and details are found to be convenient and satisfactory.

A patient, with no suicidal intention, attempted to swallow the watch of his father, who was visiting him. It stuck in his throat and was with difficulty removed.

Limerick.—Dr. Courtenay directs attention to the great difficulties which exist in Ireland in placing lunatics under early treatment. He says:—"It is, therefore, of the utmost importance that the form of admission for the poor and uneducated should be made as simple and easily obtainable as possible. Unfortunately the only order now used in this country necessitates that some offence should have been committed by the lunatic before it can be put in force, and the various steps to have it perfected are extremely complex and difficult to carry out in remote districts. The introduction of the order under Vic. 16 and 17, Sec. 97, would be of the greatest service in the treatment of the insane, as insuring perfect simplicity, preventing any delays in compilation, and at the same time affording proper legal protection to both the lunatic and next of kin."

We reproduce the following paragraph by way of a warning note, as it shows that much harm may be done by sending patients to Irish workhouses:—"Patients who were harmless, well-behaved, and without hope of recovery were sent to their various workhouses, so as to prevent this institution becoming overcrowded; some of these were sent back in much worse condition than when discharged. Year after year we hear of the same panacea for the increasing number of chronic lunatics, viz., their removal to the workhouse; but it is only necessary for anyone who takes any interest in the insane to watch the result of these transfers, to be satisfied that such a scheme is utterly impracticable, and can never be carried out to any extent, except at great expense or great injury to helpless human beings."

Nothing impresses our mind so forcibly with the backwardness in education and general enlightenment of the Irish people, than the small number of post-mortem examinations made in the asylums. At Limerick only five were made in the year.

That the asylum is managed with energy and enterprise is evident, but we are at a loss to understand how the patients obtain sufficient exercise beyond the airing courts. The asylum is surrounded by buildings, and the farm is only a few acres in extent—about 12 are in cultivation. Such a condition of things must make the management peculiarly difficult.

Middlesex. Banstead.—At the end of 1883 there were 1,884 patients in the asylum, and accommodation is in process of completion for 120 women. Surely this asylum has now reached its limit; we cannot but express an opinion that it is at least double what it should be. Built originally for chronic cases only, it admits all kinds, and is under the direction of one medical superintendent.

The proportion of attendants to patients is only 1 to 17—an unusually low one. The Commissioners remark that though the staff may suffice for the care of the patients in the wards, it appears to them to be insufficient for the proper exercise of the patients out of doors and that employment of many which is so conducive to their health, and even mental recovery. At Prestwich, the proportion of attendants to patients is 1 to 7, and the result is most satisfactory.

Relative to the employment of patients, Dr. Shaw writes:—"It is in preparing patients to resume their place in society that is found one of the chief values of employment, whilst they are still in the asylum, for by it they are prevented from developing laziness, and when discharged they find themselves in better trim for self-help. Although in some respects it is better for the asylum to employ patients in the occupation to which they have been brought up, it is, I think, often more advantageous to give them a change of work, for change means rest, and to keep a person at his old familiar work is to bring back all his old ideas. I should like to see some system introduced by which pecuniary aid could be given to patients on their discharge. At present the motive to work is extra indulgence, for it cannot be expected that they will work for work's sake, and in some instances the stimulus is supplied by the idea that by showing themselves capable of work they will sooner get their liberty. The subject of occupation has not been neglected here, and the recent acquisition of land has enabled us to employ as many as 200 male patients. We have introduced manual ploughing as a means of occupying, on the land, patients who cannot be trusted with spades or forks. It is a work into which they readily enter and enjoy, and has proved most successful. The want of similar out-of-doors occupation for the women is much felt, and this explains the greater noise and restlessness always to be noticed on the female side of an asylum, except, perhaps, in the laundry department, but we find it difficult here to get

patients to work in the laundry, because amongst the admissions are very few who have been laundresses, and the work seems distasteful to those who have not been accustomed to it."

Middlesex. Hanwell.—A block of 82 bedrooms has been built for nurses; each nurse has a separate room—a very good arrangement.

A new matron has been appointed at an annual salary of £345, with furnished apartments, attendance, coals, gas, washing, milk, and vegetables. She is required to board two servants. We have never been able to grasp the reason why the matron should be so extravagantly paid. At the Banstead Asylum, with an equal number of patients, the matron receives £100 per annum, with house, gas, board, and uniform. Of course there must be some very good reason. Only, granting this, we do not understand why the other officers are not paid in proportion.

Montrose.—This report contains an important minute by Dr. Arthur Mitchell on the work performed by the Montrose and the Dundee Asylums in providing accommodation for the pauper lunatics of Forfarshire. It would appear that the long-standing dispute between these asylums and the District Board is approaching a settlement.

Dr. Howden again directs attention to the necessity for providing a detached hospital where the sick and infirm could be treated apart from the healthy inmates of the main building. The asylum is quite full, parts of it, indeed, crowded. In one day-room each occupant had less than 22 square feet of floor space, and in the dining-hall 377 patients were seen at dinner by the Commissioner; the backs of the chairs touched each other, and there were only 10 square feet for each patient.

Murray Royal Asylum.—Dr. Urquhart continues to report favourably on the open-door system. He says:—"We have now more than half the house conducted on the open-door system, and that without involving the troubles and dangers that might have been expected. It is right to add that this arrangement is highly prized by the patients, and does not press unduly on the attendants. To-day, out of 84 patients, 15 are recorded as being on parole beyond the grounds, and 32 on parole restricted to the grounds—47 in all. It is rare that such liberties require restriction, except in the case of patients suffering from recurrent excitement."

Three cases of typhoid fever occurred in the male division during the summer, and another in winter. Although no cause could be discovered for the appearance of this disease, no doubt one existed.

Extensive structural improvements were effected during the year, and have resulted in increased comfort and cheerfulness.

Newcastle.—The population of this asylum continues to increase, and it is quite evident that the day is not distant when important enlargements must be begun. Some additions to the day space of one of the wards have been made, and the management of the patients has been much facilitated.

Concerning the discharge of patients Mr. Wickham writes:—"The discharge 'recovered' of a patient who has been for any length of time in an asylum often depends on other circumstances, in addition to his own mental state. He may be apparently recovered, but in such a state that were he removed from asylum supervision, and no proper substitute made for it, his mental equilibrium would be again destroyed, and if his latter condition were not actually worse than his former, he would at any rate have to go through all his months, or it might be years, of excitement or despondency before it was restored. To consent to recommend such a case for discharge is a very delicate matter, and to refuse is equally so, and one of my most painful and thankless duties consists in resisting the importunity of injudicious relatives, who can 'see nothing wrong with him.' Table I., which shows that, of the total number admitted in 1883, 24 per cent. were cases of re-admission, is sufficient evidence of this; and many of these were much aggravated by but a short sojourn away from my supervision. I am willing to acknowledge that some cases of which I had misgivings did better than I thought they would, but they were those in which I had not the means of duly estimating the very suitable care and attention which they were to receive."

Norfolk.—Dr. Hills records an epidemic of pneumonia in which not only patients, but the lower animals were affected. These outbreaks are very curious. The general result of enquiry has been to find that the same disease is prevalent in the neighbourhood at the same time. A well-marked epidemic of the same kind occurred at the Crichton Institution a few years ago.

"During the first few months of 1883 we had an epidemic of pneumonia, in all 15 cases, viz., 11 men and four women. The majority of these patients were on the male side of the annexe, where the ventilation and other sanitary matters are all that could be desired. The prevailing winds during this epidemic were south and south-west until the sun crossed the line, when they changed to north-east. The site is high, dry, and exposed, and the state of the atmosphere throughout the visitation was damp and cold; several dogs and one cat were affected with pulmonary catarrh in various forms, and the illness began like that of distemper, with fever, loss of appetite, cough, &c.; one of the animals died of the complaint, several were in a critical state, and in two it left impairment of the respiratory organs. I learnt that in the district generally there was at this time a prevalence of pneumonia. The only conclusion I could draw from a careful observation of the facts was that the cold, damp weather, acting upon individuals whose nervous powers were already depressed, caused them to fall an easy prey to influences which healthy subjects might have resisted."

The Commissioners direct attention to the small proportion of day attendants, there being only one to eighteen in the male, and one to seventeen in the female division.

Northampton.—The enlargements are now partly occupied, and the overcrowding has been relieved.

Whilst the visitors think that the capitation-grant paid to unions has offered an inducement to transfer patients from workhouses to asylums, they very judiciously add that it may also have a tendency to ensure the speedy treatment in acute cases. This is a view of the case too often lost sight of.

Northumberland.—Extensive additions and alterations are to be made to this asylum at an estimated cost of about £28,000.

“As in former years, exercise beyond the airing courts, in the grounds and surrounding country, has been accorded to almost all who are fit to enjoy it. The lame and such like cannot join the walking parties, and only about six patients of each sex are denied the privilege of walking beyond the airing courts. These exceptional cases are restricted in their exercise because of their violence, indecency, or persistent efforts to escape. Especially among women, exercise in airing courts is not conducive to health and good conduct, and it is my present intention that there shall be no exercise ground within walls or railings in the new wing for female patients. When they are permitted to exercise in the open country they enjoy their liberty, very seldom abuse it, and those in charge are more impressed by the responsibility of their work. It is extremely creditable to the patients and their attendants that during the past year almost no escapes have occurred, and none of such a character as to imply neglect. When a patient on parole, or one who is placed under a minimum of supervision, abuses his liberty and runs away, no fault need be laid at the door of those in charge; indeed, an entire absence of such escapes would show that the discipline was too severe. The circumstances are, however, entirely altered when a patient under special supervision escapes, for then those in charge become liable to serious penalties, and justly so.”

Norwich.—Continued efforts are made to put this asylum into thorough working order, and the management appears to be energetic and enlightened.

The following short paragraph from Dr. Harris's report is important, and may suggest an admirable arrangement to other superintendents:—

“Communication between the dormitories and attendants' mess-rooms (also occupied by the night attendants, when on duty) has been established by means of electric bells, in 14 instances, and the hoped-for success of the system fully realized. It may not be out of place to draw your attention to the fact that this is the *first* asylum in which such provision has been made for the use of patients mentally afflicted, and it is gratifying to find mention made of this in the Blue Book.”

Nottingham Lunatic Hospital.—This institution continues to do a good work amongst the poorer middle classes. The visitors report

that no fewer than 40 out of the 78 patients in residence are benefited by the charity fund. The hospital was founded nearly a hundred years ago. Its chief object is to afford assistance to persons of the middle class, for whom, when they become insane, no provision is made except in this and similar institutions, and who, being deprived of the power of supporting themselves, have no alternative but the workhouse or pauper asylum.

The Commissioners report that the substantial comforts of this hospital will, in their opinion, bear comparison with any in the country.

Dr. Tate is to be congratulated that he can report that in 25 years restraint has never been employed, and seclusion on only one occasion. He has always endeavoured to assimilate the establishment to a large domestic circle, and to make it as home-like as possible, and he has great satisfaction in knowing that he has so far succeeded that many of his patients have left him with feelings of gratitude and friendship not likely to be effaced.

Nottingham. Borough.—The Commissioners very properly point out that one medical officer for an asylum containing from 275 to 280 patients is quite inadequate. When Mr. Powell is absent, and he must be occasionally away for several hours for exercise, it is not right that there should be no medical officer present to receive patients and attend to any accident which may occur.

The asylum is already full. Eight patients were accordingly given over to the care of their relatives, and four were sent to the workhouse; but of these latter two have been returned, though Mr. Powell cannot discover that they are in any way dangerous to themselves or others.

A male patient was admitted in a state of active delirium; in a short time he manifested signs of typhus fever and died. Fortunately the disease did not spread.

Oxford.—The post-mortem examinations made during the year were unusually small: only 13 in 42 deaths. The Commissioners point out that in some of the wards the staff was weak. In one ward with 50 patients, 20 of whom are epileptic, there were only three nurses; and most of the wards were entrusted to two attendants.

A detached chapel has been erected, and is now in use.

(To be Continued.)

4. Colonial Retrospect.

Report of the Inspector-General of the Insane for New South Wales.
1883.

Dr. Manning again presents us with an interesting report of his important department, which shows that he and those who are co-operating with him are discharging responsible duties in an efficient manner.

The number of insane persons in the Colony still shows a progressive

increase, but, fortunately, not out of proportion to the increase of population.

The following tables are of considerable interest :—

Year.	Population of New South Wales.	Total Number of Insane in New South Wales on 31 Dec.	Proportion of Insane to Population in New South Wales.	Proportion of Insane to Population in England.
			Per M.	Per M.
1864	392,589	984	1 in 399 or 2·50	1 in 457 or 2·19
1865	411,388	1,037	1 in 396 or 2·52	1 in 445 or 2·24
1866	431,412	1,114	1 in 387 or 2·58	1 in 436 or 2·29
1867	447,620	1,155	1 in 387 or 2·58	1 in 424 or 2·35
1868	466,765	1,230	1 in 379 or 2·63	1 in 411 or 2·43
1869	485,356	1,226	1 in 395 or 2·53	1 in 403 or 2·48
1870	502,861	1,289	1 in 389 or 2·57	1 in 400 or 2·50
1871	519,182	1,387	1 in 374 or 2·67	1 in 394 or 2·53
1872	539,190	1,440	1 in 374 or 2·67	1 in 387 or 2·58
1873	560,275	1,526	1 in 367 or 2·72	1 in 381 or 2·62
1874	584,278	1,588	1 in 367 or 2·72	1 in 375 or 2·66
1875	606,652	1,697	1 in 357 or 2·80	1 in 373 or 2·68
1876	629,776	1,740	1 in 361 or 2·77	1 in 368 or 2·71
1877	662,212	1,829	1 in 362 or 2·76	1 in 363 or 2·75
1878	693,743	1,916	1 in 362 or 2·76	1 in 360 or 2·77
1879	734,282	2,011	1 in 365 or 2·74	1 in 363 or 2·75
1880	770,524	2,099	1 in 367 or 2·72	1 in 353 or 2·83
1881	781,265	2,218	1 in 352 or 2·84	1 in 352 or 2·84
1882	817,468	2,307	1 in 354 or 2·82	1 in 348 or 2·87
1883	869,310	2,403	1 in 361 or 2·77	

Year.	Admissions.	Population.	Proportion to Population.
1864	199	392,589	1 in 1,973
1865	182	411,388	1 in 2,260
1866	196	431,412	1 in 2,201
1867	181	447,620	1 in 2,473
1868	223	466,765	1 in 2,093
1869	265	485,356	1 in 1,831
1870	253	502,861	1 in 1,987
1871	340	519,182	1 in 1,527
1872	303	539,190	1 in 1,709
1873	342	560,275	1 in 1,638
1874	330	584,278	1 in 1,770
1875	356	606,652	1 in 1,704
1876	360	629,776	1 in 1,749
1877	457	662,212	1 in 1,449
1878	424	693,743	1 in 1,636
1879	440	734,282	1 in 1,668
1880	476	770,524	1 in 1,618
1881	494	781,265	1 in 1,581
1882	473	817,468	1 in 1,723
1883	476	869,310	1 in 1,826

In the following table are shown the results of treatment during the last eight years :—

Year.	Percentage of Recoveries on Admissions and Re-admissions.			Percentage of Patients relieved on Admissions and Re-admissions.			Percentage of Deaths on average numbers resident.		
	M.	F.	Total.	M.	F.	Total.	M.	F.	Total.
1876	40·90	50·72	44·75	7·90	13·76	10·19	7·41	5·41	6·73
1877	42·28	51·61	44·86	4·97	14·51	7·81	8·58	3·78	7·05
1878	42·85	28·05	37·01	6·75	12·19	8·89	8·42	4·83	7·24
1879	39·86	37·66	39·08	7·47	18·18	11·26	7·66	4·19	7·10
1880	45·08	36·00	41·70	7·11	10·85	8·51	7·68	6·01	7·10
1881	41·69	45·34	42·91	5·01	8·69	6·25	6·39	3·71	5·46
1882	38·56	50·29	42·70	7·18	9·58	8·03	6·68	5·62	6·27
1883	40·61	40·98	40·75	6·48	6·01	6·30	7·69	4·98	6·64

Dr. Manning has some interesting observations upon the use of restraint. He says—

“It has not been deemed advisable to lay down any hard-and-fast rule as to the cases in which it is or is not to be employed. Its use is left entirely to the discretion of the physician in charge, and it is prescribed in the same way as a dose of medicine, an extra quantity of food or stimulant, a shower or warm bath, or any other remedy.

“At all my visits of inspection I take care to see every patient in restraint, and inquire into the necessity for its use, and I have on several occasions caused returns to be prepared which show the amount in use at all the institutions at one time. These returns show that the amount never exceeds one patient in restraint out of every 400, or $\frac{1}{4}$ per cent., and is frequently much less, and that in half of the cases it is employed for surgical reasons, to allow of the healing of wounds or other injuries, or to prevent the irritation or causation of troublesome sores. Hospitals for the insane can of course be managed altogether without mechanical restraint. Some of the best in the world are so, and in one institution in this Colony no restraint has been employed for nearly three years; but my experience, gathered from a wide field in the hospitals of Great Britain, Ireland, France, Germany, Belgium, Holland, and Italy, as well as in the United States and a number of the Colonies, has not convinced me of the wisdom of total disuse of this agent, and has certainly led me to believe that any hard-and-fast prohibition of it would be a fatal mistake. Under proper regulations it has a useful place in the treatment of insanity; and I hold that the position taken by the physicians of American hospitals is in this respect more philosophical

and more humane than the extreme views held by some alienists in Great Britain.

The following comparison as to details of weekly cost between the Borough Asylums in Great Britain and the Hospitals in this Colony is interesting:—

Average weekly cost per patient in Borough Asylums in Eng- land (taken from 37th Report of Commissioners in Lunacy for the year 1882.)			Average weekly cost per patient in Hospitals for the Insane in New South Wales.		
	£	s. d.		£	s. d.
Provisions and beer ...	0	4 7	Povisions and beer ...	0	4 10 ³ / ₄
Clothing, bedding, &c. ...	0	1 2	Clothing, bedding, &c. ...	0	2 0 ³ / ₄
Salaries and wages ...	0	2 5 ¹ / ₈	Salaries and allowances ...	0	4 3 ¹ / ₂
Necessaries—Fuel, light, &c.	0	1 3 ¹ / ₂	Fuel and light	0	0 6 ³ / ₄
Surgery and Dispen- sary — (Medicines, &c.)	0	0 0 ³ / ₄	Medicines	0	0 1 ¹ / ₄
Wines and spirits	0	0 0 ⁵ / ₈	Wines and spirits	0	0 0 ³ / ₄
Farm and garden (less produce sold)	0	0 3 ¹ / ₈	Miscellaneous — (in- cluding amuse- ments, incidental expenses, materials for employment of patients and minor repairs)	0	0 7
Miscellaneous	0	0 7 ³ / ₄			
	£0 10	5 ⁵ / ₈		£0 12	5 ¹ / ₈

“It will be seen that the main difference in cost is due to the amount for salaries and wages being larger in this Colony than in England. The salaries paid to officers are not as a rule higher than in Great Britain, but the wages to attendants, nurses, and servants are very greatly in excess of the English rates.”

The insufficiency of accommodation for the insane population of the Colony, to which reference has been made in Dr. Manning's previous reports, appears to be in a fair way to be remedied by the completion of new buildings and the utilization of old ones, which may be rendered available for the purpose.

Altogether there would seem to be an intelligent administration of the lunacy department of the Colony such as might reasonably be expected under Dr. Manning's enlightened guidance.

FREDERICK NEEDHAM, M.D.

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Quarterly Meeting of the Medico-Psychological Association was held at Bethlem Hospital, May 8th, 1885, Dr. H. Rayner, President, in the chair. There were also present Drs. James Adam, C. Aldridge, S. H. Agar, H. A. Benham, Fletcher Beach, E. H. Byas, G. F. Blandford, S. W. Bryant, D. Bower, P. E. Campbell, C. S. W. Cobbold, Elliott, J. E. M. Finch, J. R. Gasquet, Henry Hicks, John B. Isaac, Robert Jones, Octavius Jepson, Henry Lewis, Edward Lister, James Mills, W. J. Mickle, A. Newington, H. H. Newington, David Nicolson, S. Rees Philipps, J. H. Paul, Joseph Rogers, T. L. Rogers, G. H. Savage, W. J. Seward, H. Stilwell, James Shaw, H. Sutherland, G. E. Shuttleworth, D. Hack Tuke, C. M. Tuke, D. G. Thomson, W. Wood, J. F. Woods, T. Outtersen Wood, J. Bywater Ward, E. Willett, Francis J. Wright, H. Winslow, &c.

The following gentlemen were elected members of the Association, viz.:—

E. W. Henley, L.R.C.P., Senr. Ass. Med. Off., County Asylum, Gloucester.

J. G. Soutar, M.B., C.M., Ass. Med. Off., Barnwood House, Gloucester.

C. Mortimer, M.B., Res. Student, Bethlem Hospital.

J. T. Keegan, Ass. Med. Off., Indianapolis, Ind., U.S.A.

F. C. Gayton, M.B., C.M., Senr. Ass. Med. Off., Brookwood, Surrey.

The PRESIDENT said that the Council had that day received a report from a Sub-Committee which they had appointed to consider the question of the grant-in by the Association of certificates in psychological medicine.

Dr. HACK TUKE said that the proposal referred to, which was a very important one and emanated from the Council, evidently required the authorization either of a special general meeting or of the annual meeting. If the annual meeting had not been so near at hand it would, perhaps, have been well to have a special meeting to consider the subject, but as the annual meeting was not very far off, he would, unless the members preferred calling a special meeting, move that the report be referred entirely for consideration to the annual meeting, which would be held at Cork.

This motion was seconded by Dr. FLETCHER BEACH, and declared to be carried.

Dr. W. WOOD moved the following resolution:—That, contemplating the probability of the retirement of Lord Shaftesbury from the Lunacy Commission, it is proposed that at the annual meeting an expression should be arrived at in recognition of his lordship's long and valned services, and that it be accordingly referred to a Sub-Committee, consisting of the President, Dr. Hack Tuke, Dr. Lockhart Robertson, and Dr. Clonston, to prepare a suitable address to his lordship for adoption at the annual meeting." Dr. Wood said that it would be premature to do more than this at present, as they had as yet no official notice of Lord Shaftesbury's retirement, and they might yet hope that his lordship would reconsider his decision.

Dr. SAVAGE seconded the motion, which was carried.

The PRESIDENT said that the next business was to receive what might be taken as the report of the Parliamentary Committee of the Association. Copies were submitted of suggested amendments and remarks on the Lunacy Acts Amendment Bill, 48 Vict., together with a copy of the address of the deputation of the Association to the chief secretary of the Lord Chancellor on the 20th April last. (See Notes of the Quarter, &c.) The President said that as to the great point in the address and in the whole question—the introduction of magisterial authority in the certification of private lunatics—it would be seen that the Committee had expressed their opinion that this

was undesirable. Some question had been raised as to the desirability of the Committee expressing any opinion as to the probability of the proposition for magisterial intervention passing the Legislature, and perhaps it might have been well if no opinion or words had been uttered in regard to that probability, but every member of the Association could judge for himself as to whether this portion of the Bill was or was not likely to pass. In the event of the Bill passing it had been endeavoured, as far as possible, to qualify the magisterial intervention, and to make the function of the magistrate purely ministerial. Suggestions had also been made with the object of shielding medical men signing certificates from the persecutions to which they had been subjected; and the Committee had also expressed their opinion as regards the extreme penalties awarded by the Bill. It appeared to him that the penalties could scarcely have been more severe and harsh.

In reply to Dr. T. L. Rogers, the PRESIDENT said that the chief secretary to the Lord Chancellor could only hear the opinions, and could not say anything definite further than that due attention would be given to the representations of the deputation.

Dr. SAVAGE said that, with a view to bring out discussion, he should be very glad to express his feeling, in the first place that magisterial interference was not desirable, and in the second place that, if it should be accepted, the least objectionable way of doing it would be as proposed in the report of the Committee, viz., that the magistrates should examine the certificates, and not the patients. He would propose to this effect.

Dr. JOSEPH ROGERS supported Dr. Savage's motion, saying that under the existing system the insults put upon men of his own class by having their opinions contravened by stipendiary magistrates, and the injury done to the lunatic thereby, rendered it most objectionable that the stipendiary magistrate should be introduced into the Bill. Twenty-five years ago there was a distinct expression of opinion on the part of the Commissioners in Lunacy that, if it could be avoided, pauper lunatics should not be taken into a police-court to be examined by a stipendiary magistrate, and he had himself carried out the Commissioners' suggestion as far as he could; but, unfortunately, in the Strand Union some years ago there ceased to be an unpaid magistrate, and he had been obliged to take his cases to the police-court. He remembered that in one case he challenged the decision of the magistrate and said, "I shall not let this person go as you direct. I have my duty to do." The magistrate said, "Bring him down here next week." He (Dr. Rogers) wrote to the Commissioners in Lunacy, and they immediately sent two of their body to the Workhouse, and came to the conclusion that the man was a dangerous lunatic, and he was sent to an asylum. He could quote cases which he had certified four and five times before he could get them sent to an asylum. In one case, on the fifth occasion, he heard that the magistrate had gone for a holiday, and the case came before another magistrate, who made an order directly, and the patient was sent to Hanwell, where she would remain all the rest of her life. He thought that it was time that a stop was put to this. It all arose from the circumstance that they had no one in the House of Commons prepared to protect their profession from those insults. He entirely agreed with Lord Shaftesbury's conclusions. The police magistrates treated lunatics like criminals and not like patients.

The PRESIDENT said that it was very interesting to members of the Association who had to deal principally with the certified lunatic, the "manufactured article," so to speak, to hear the difficulties those had to undergo who had to get patients certified.

Dr. BOWER said that the practice was absolutely dissimilar in Scotland. There the Sheriff simply had to test the form of the certificate and see that it was right and that the medical men were properly qualified. He saw neither the medical man nor the patient. He received half-a-crown for signing the order, and it had been held that the Sheriff had no right to refuse to sign the order if it was in due form.

Dr. HACK TUBE read a portion of a letter from Dr. Yellowlees upon this subject, in which he said:—"I have not the very smallest doubt that the Sheriff's order has prevented actions being brought against medical men signing certificates and against superintendents, for assuredly the public and the patients regard his order as a *judicial* act. This is certainly my own view, and the Sheriff's warrant would be my first defence if an action were brought against me. If the Sheriff's signature merely attests the technical accuracy of the manner in which the petition and the medical certificates have been filled up and signed, it is an utterly meaningless and useless formality, and it seems absurd that a judge should grant an order depriving a citizen of personal liberty without considering the grounds on which such an order is asked. My notion is that those Sheriffs who deem it but an official act merely wish to shirk a delicate, and often a difficult, and always a serious duty, and to throw all the responsibility on the doctors. The doctors must, of course, be held responsible for the accuracy of the facts and the soundness of the opinions in their certificates, but the Sheriff has the responsibility of deciding whether they justify him in sending the patient to the asylum."

Dr. URQUHART fully endorsed Dr. Yellowlees' remarks, and observed that it seemed to Scotchmen a little extraordinary that so much should be said against magisterial interference in England. It was in Scotland regarded as a great protection. In case of complaint on the part of patients, they were immediately referred to the Sheriff, and, not only that, but the Sheriff judged of the patient's state by the certificates present on the schedule. For instance, he had a case of senile dementia—a lady who was admitted on a certificate of urgency. The certificates only bore on the face of them that the patient was in a state of fatuity, and the Sheriff refused to grant his order upon those certificates. The doctors were referred to, they filled the certificates up more fully, the Sheriff granted his order, and the papers were then deemed complete. He repeated that in Scotland they looked upon the Sheriff as a great protection, especially in dealing, as many of them did, with private patients, because the private patients knew the authority of the Sheriff and would often be content to refer the matter to the Sheriff, who might or might not take steps upon the complaint of the patient. To object to this part of the Government Bill was to prevent their having in England the very thing medical men wanted—protection from action.

Dr. ADAMS said that the Memorandum on the Lunacy Acts Amendment Bill gave it to be understood that the principles of the Scotch procedure with regard to admission had been introduced into it, and it would accordingly be of interest to examine in what manner that procedure worked practically in Scotland. Theoretically, it appeared to furnish safeguards against the improper confinement of persons as lunatics, but did it do so practically, or as effectually as the existing English Acts? To enable an answer to be returned to these questions it was necessary to enquire into the every-day practice with regard to placing private patients in asylums in Scotland. In the first place, he believed that much use was made of the certificate of emergency, or the "certificate of convenience" as it was often more properly called, for it was constantly used in cases where there was no real emergency, and merely for the purpose of having the patient housed (especially when brought from a distance) in the Asylum for three days whilst further legal documents were procured for more permanent detention. The medical man who signed the emergency certificate as a rule also filled up one of the more permanent certificates. At the same time a friend, who had in the meantime filled in the form of petition undated, or the asylum authorities, would procure another medical certificate, whereupon some person, very often an asylum official would proceed to obtain the Sheriff's warrant. This was a purely formal proceeding, for the Sheriffs in Scotland interpreted their functions in this respect as simply ministerial. They examined the petition and medical certificates to see whether they were in due form and, if so, they signed the warrant, not

even seeing the patient or pushing enquiries regarding him or her. It might be remarked that this duty of examining documents was at least equally well performed by the Commissioners in Lunacy in England. In other cases (which, however, in his experience were quite exceptional with regard to private patients) the petition, medical certificates, and Sheriff's warrant were obtained before the patient was brought up for admission. An idea seemed to prevail that if the magistrate's order were introduced into the English Act it would protect the medical certificates, which would certainly require to be done ere long if medical men were ever to resume that duty. This did not appear to be the case with regard to the Sheriff's warrant in Scotland, for, if he was not mistaken, some had found there, by rather unpleasant experience, that the Sheriff's warrant protected neither medical certifiers nor asylum superintendents from the chances of wholly unjustifiable and vexatious litigation. It was reported in the "Times" that the Lord Chancellor, in introducing the Bill to the House of Lords, had remarked that there was nothing to prevent Justices purchasing for a fair value existing licensed houses. It was worth while to note that Clauses 47, 48, and 49 of the new Bill contained no such provision in so many words, and it behoved private asylum proprietors to have that point made clear, otherwise they might be gradually supplanted by newly-erected public asylums without compensation of any kind being made.

Dr. HAYES NEWINGTON said that being personally well acquainted with the English and Scotch systems he did not think that the proposed alteration in the English law would be liable to be attended by such evils as were anticipated. The certificate of emergency was very broad and would cover every needful case. In Scotland three cases out of four were sent under certificates of emergency—therefore, no harm was done by delay. He thought, however, that any mischief likely to be created by the Bill would be in spreading the news of the insanity of the patient to his neighbours, and Lord Shaftesbury had certainly hit the right nail on the head on that point. It would be very difficult for people to go and select their magistrates: they must select the one nearest at hand. He gathered that Dr. Rogers did not object to the county magistrates, but rather to the county-court judges and stipendiary magistrates. If the paid magistrates were brought in in this way, it would be not only the judge but also all his officials who would get to know about the case. He really believed that ordinary county magistrates would not be at all likely to put themselves forward in the face of the doctors, although they knew from Dr. Rogers' statement that the paid magistrate was only too likely to do so. Lord Selborne in introducing the Bill rather apologised for introducing the county magistrates because there were no other better officials, but he (Dr. Newington) thought they would be by far the best kind of people. He did not think that there would be much harm done after the first year or two, and if there was not much harm to be feared he thought the less they discussed that part of the new Bill the better it would be. They were not likely to get the least alteration in this part of the Bill, and he did not think the lawyers would listen to any remonstrance. They must take it that the Bill would eventually come, and they had better direct their attention to cutting out the objectionable details. He thought they ought to strain every nerve to prevent any judicial people actually seeing the patient. This would be thought absurd in cases of bodily disease, and he considered that if magistrates must see patients mentally afflicted there would be much harm done.

The PRESIDENT remarked that the question appeared to be whether there was any essential difference between the action of the magistrate as proposed by the English Bill and the present state of things in Scotland.

Dr. ADAM said that the Sheriffs had stated that they considered their duty as strictly magisterial, or rather ministerial—simply seeing that the documents were all right.

Dr. BLANDFORD referred to a case in an evening paper where a man had

been taken before a magistrate (not a stipendiary), who had marked the book "not insane." Probably he was in a state of melancholia, and answered questions rationally. The man committed suicide shortly after. He thought that if the magistrates were to examine patients, and judge themselves of their insanity, they might just as well do the whole thing themselves and not consult the doctors.

The PRESIDENT mentioned a somewhat similar case, in which a woman who had been certified and refused was returned to the workhouse, and roasted her child.

Dr. BLANDFORD said that if magistrates were so particular about pauper cases they were likely to be far more particular in regard to private individuals, especially where they were persons of any mark and likely to create any disturbance after their release.

Dr. T. L. ROGERS said that he thought they should be careful not to say that the interference of a magistrate was undesirable, unless they had an alternative to suggest. If they could make no suggestion as an alternative they might as well let it pass, and endeavour to curtail the mischief as much as they could. Let them accept the principle and get good out of it.

After some further discussion, the PRESIDENT put to the meeting the following motion, as moved by Dr. Savage, and seconded by Dr. T. L. Rogers, viz.:—"That we are almost unanimously of opinion that the intervention of the magisterial authority (as provided by Clause 2), prior to the granting of an order for the treatment of a person of unsound mind, is *undesirable*, and will lead, if adopted, to delay in treatment, to attempts at evasion of the law, and other untoward results. On the other hand, we fully recognise the probability that this proposition for magisterial intervention will pass the Legislature; and, should this occur, greatly as we deprecate such an event, we find it difficult to suggest any officials for carrying out this provision other than those indicated in the Bill."

The motion was declared to be carried.

Dr. JOSEPH ROGERS referred to the provisions of the Bill by which the officiating clergyman and relieving officer were to be deprived of the power of signing orders. This seemed to be a needless slight upon clergymen, who would thus be debarred from coming to the assistance of poor sick lunatics, thereby making certification of lunatics more difficult than at present, and he could see no reason why it should be done except that the lawyers were trying to get all the power into their own hands. He could instance several cases where the intervention of clergymen had been attended by the happiest results.

Dr. BLANDFORD moved: "That the meeting is of opinion that the power of the magisterial authorities should be purely 'ministerial,' and that, when any doubt on medical questions arises, these officials should not personally visit and examine the alleged lunatic (as provided in the Clause), but only have power to direct a further medical examination."

Dr. WILLETT seconded the motion.

The PRESIDENT said it certainly did seem extraordinary that a purely medical question should not be settled by a medical man. If there were any doubt on the medical questions, it would certainly be much better that it should be settled by a medical assessor.

Dr. NICOLSON suggested whether, as the proposal then stood, they might not lay themselves open to have it said that they wished to have something done in secret, when, in fact, they had no wish of the sort. That was the risk he thought they would run in debarring the magistrate from visiting the patient. They should avoid saying anything which might be offensive. The matter should be looked at all round. It was not merely certifying a man to be a lunatic; the man was deprived of his civil capacity, and shutting a man up in a lunatic asylum meant a great deal more than sending him to a hospital. He thought the public were quite right in saying that everything should be done

in the interests of the patient. He did not think that magistrates had any wish that a lunatic should be kept at home. They only wished—as medical men themselves desired—that no lunatic should be deprived of fair and proper consideration and treatment when the patient might be said to be unable to judge of his affairs. The magistrate might have his own opinion as to carrying out the rules. What they had to get at was the principle by which the magistrate was to be guided. If a magistrate overstepped the rule they could not blame the law for it, but the particular magistrate.

Dr. BYWATER WARD said that if the magistrate were not allowed to see the patient it would scarcely seem reasonable that his signature to the order should debar, as was so desirable, any legal action against the medical man who signed the certificate.

Dr. HICKS suggested whether it would not be better to say that the magisterial examination should not supersede the opinion of the medical man, and merely call the attention of the Commissioners to any special point of detail.

Dr. COBBOLD said that it was in the interest of the patient that they objected. Their objection only went so far as the actual questioning of the patient by the magistrate. Perhaps it would meet the views of the meeting if it were provided that magistrates should not personally examine the alleged lunatic except where it was necessary for them to do so.

Dr. NICOLSON said that "where necessary" was the point of the whole thing.

Dr. ADAM pointed out that in the Memorandum on the Bill it was stated that in order to give the county court judge, magistrate, or justice something more than "merely ministerial" functions in cases requiring investigation, he was empowered, if he considered the statements in the medical certificates unsatisfactory, to make inquiries, and, if he thought it "*necessary*," to visit the alleged lunatic.

Dr. NICOLSON said that it would probably meet Dr. Blandford's views if it were provided that the magistrate should not be set over as a kind of censor. His magisterial powers would begin when he interfered with the medical opinions.

The PRESIDENT said that that would be met by the suggestion that if he were in doubt he should appoint a medical assessor to assist him.

Dr. ADAM suggested that it would be well if it were inserted in the Bill that the powers assigned to magistrates should not go beyond the powers already assigned to the Sheriff in Scotland.

Dr. URQUHART referred to a Scotch case in which the Sheriff considered that the evidence of insanity was insufficient. He did not go and examine the patient himself, but referred the matter back to the doctors who had originally certified. If that practice was followed, as far as possible, in England he thought it would meet the case.

It was then agreed to omit the reference to the visit and examination, and it was resolved that the power of the magistrate should be purely ministerial, and that when any doubt on medical questions should arise the magistrate should only have power to direct a further medical examination.

On the question of some protection being given to medical men signing certificates, which was next raised, Dr. HACK TUKE said that this would be all the more necessary now that the meeting had so clearly expressed their opinion that the duties of the magistrate should be purely ministerial, because, of course, the responsibility would be correspondingly thrown upon the medical men. If they had adopted the principle of the Bill that the action of the judge or magistrate should be more than simply ministerial, in short, judicial, medical men would have been, he believed, greatly protected. He might mention that the College of Physicians had appointed a committee for the consideration of that special subject of safeguard. He hoped the Lord Chancellor would introduce a clause specially guarding medical men from actions.

Dr. SAVAGE said that the committee appointed by the Metropolitan Branch

of the British Medical Association objected most strongly to the introduction of the Public Prosecutor. They thought it would be better that no prosecution against the signers of orders or statements and certificates should be had without the consent of the Commissioners in Lunacy. While the Commissioners had no interest in detaining the patients, they had every interest in seeing that the certificates should be signed in good faith. Let the Public Prosecutor be the medium, if necessary, but let the Commissioners be the persons responsible for stopping or proceeding with prosecutions. He thought it should be that the proceedings should not be taken except with the consent of the Commissioners in Lunacy, backed by the Public Prosecutor.

Dr. NICOLSON entirely opposed the view taken by Dr. Savage, saying that they regarded themselves as swimming in the same boat with the Commissioners in Lunacy, who were their supervisors, and to refer the matter to them would, surely, be scarcely fair to individuals wishing to prosecute medical men. He objected still more strongly to the Public Prosecutor. If a case were referred to him, and he said, "No, there is no case here," there would be no harm done; but if he said, "Yes," it would be rather damaging to the person prosecuted. The provision in the Statute ought to make all preparations and anticipate any risk, and should bear on the face of it clearly in some way that a medical man "knowingly falsifying," or "knowingly entering something wrong in his certificate," and so forth, should be liable to prosecution. As he had before remarked, referring it to the Commissioners in Lunacy would not mend matters at all. That would be asking them to judge of their own affairs. They were supposed to have decided on those matters long before, and would not stultify themselves.

The PRESIDENT said that the arguments Dr. Nicolson had been using were precisely those which decided the Committee to leave out the Commissioners and not associate them with the Public Prosecutor in the matter. It was difficult to suggest an alternative for the Public Prosecutor.

Mr. HAYES NEWINGTON said that there was one alternative, which was to throw all the trouble on the person who set the machine going. It was not only unfair to a medical man to be prosecuted for *mala fides*, but that he should also be prosecuted for trespass—for going into a man's house to examine him—was preposterous. Certainly, there ought to be some protection against the technical possibility of prosecuting a medical man for trespass. In a recent instance the major portion of the case turned upon the question of trespass, and it was decided against the medical man.

The PRESIDENT said that although they might not all agree as to the precise way in which protection should be given to medical men, he had not heard any contrary view expressed in the matter of there being some protection, and he took it that he might now put it to the meeting that medical men should be protected in obtaining and signing certificates.

This proposition was unanimously adopted.

Mr. C. M. TKE suggested whether, under the circumstances, it would not be more dignified if a preliminary resolution were passed expressing their opinion that the Bill itself was undesirable and unnecessary, the attacks upon medical men having been always unfounded. Lord Shaftesbury seemed to think so, and they seemed to be rather jumping to the conclusion that the Bill might not be defeated.

The PRESIDENT said that the general endorsement of the views expressed in the report of the Deputation included what was indicated by the previous speaker, and that those views had been duly brought under the notice of the Legislature.

Dr. URQUHART moved: "That the Commissioners or Inspectors of Lunacy in England, Scotland, and Ireland shall have powers of removal of patients on trial, or for the benefit of their health, throughout the three countries. That the English Commissioners may grant writings under their seal to this effect, that shall be valid for Scotland and Ireland; and similarly with the Scotch and

Irish Lunacy Boards. That medical certificates of lunacy granted in England, Scotland, or Ireland shall be valid throughout the United Kingdom." At the present time a patient ceased to be a lunatic when he went across the border.

Dr. HACK TUBE seconded this proposal, which was agreed to.

In reference to a suggestion from the Parliamentary Committee that in Clause 29 of the Bill the words "infant being of unsound mind" should be substituted for "idiot or imbecile,"

Dr. FLETCHER BEACH said that at a recent conference of noblemen and gentlemen interested in the management of institutions for idiots and imbeciles, presided over by Lord Winmarleigh, a strong feeling was expressed that the words "being of unsound mind" should not be used in that relation. He might add that parents of such children preferred that they should be designated "imbeciles" rather than "persons of unsound mind."

The PRESIDENT asked whether it would be satisfactory if the words "feeble mind" were used.

Dr. SHUTTLEWORTH said that the matter had been discussed very carefully, and they wished it to be provided that any person being an idiot or an imbecile from birth, or from an early age, might be lawfully received into and retained in any registered institution for the special care and training of idiots or imbeciles upon the certificate in writing of a duly qualified medical practitioner that such person was an idiot or imbecile requiring special care, or alleged to be capable of receiving benefit from instruction and training. Under the provisions of the Bill, inmates in this kind of institution would have to be discharged upon exceeding the age of 20, which would inflict much hardship upon both the institutions and the friends of the discharged inmates, as well as upon those inmates themselves. It was also urged at the Conference, which was a very representative one, that institutions for idiots and imbeciles should not be classed as hospitals for lunatics. He submitted a report of the Conference.

Dr. COBBOLD said that they had some reason to hope that amendments would be introduced into the Bill in the sense indicated. The words, "has been imbecile from an early age" would meet the case.

Dr. URQUHART laid on the table a proof of a "Handbook for the Instruction of Attendants on the Insane," prepared by a sub-committee of the Medico-Psychological Association, appointed at a Branch Meeting held in Glasgow on the 21st February, 1884. The Handbook would be published by Messrs. Baillière, Tindall, and Cox, 20, King William Street, Strand, W.C.

The members then proceeded to the grounds of the Hospital to witness some experiments by the Harden Star Hand Grenade Fire Extinguisher. A water-closet sent by Dr. Urquhart from Perth was also on view.

SCOTCH MEETING OF THE ASSOCIATION.

A quarterly meeting of the Medico-Psychological Association was held at the Royal College of Physicians, Edinburgh, February 27th. Present: Drs. Campbell (Perth), Carlyle Johnstone, Campbell Clark, Clouston, Howden, Ireland, McLaren, Rutherford, Turnbull, Yellowlees; Dr. Ireland in the chair.

Dr. CARLYLE JOHNSTONE read the following "Notes of a case of profound and somewhat prolonged Suicidal Melancholia; Diarrhoea with Fever; Recovery." (See "Cases.")

Dr. CLOUSTON remarked that in this case it was probable that a change of nutrition had followed the acute febrile attack, which resembled typhoid fever. This change was frequently observed in children, who sometimes improved in general nutrition after an acute febrile disorder as scarlatina or measles. In the case in point the patient was a degraded melancholic, somewhat demented. The prognosis was hopeless, yet she recovered. This was no doubt due to an alterative febrile change.

Dr. CAMPBELL (Perth) mentioned that after an epidemic of typhoid fever, which occurred some years ago at Durham Asylum, an improvement took place in many cases, and in three, who had the fever, and who had been regarded and classified as incurably insane, recovery occurred.

Dr. HOWDEN said he had often observed an acute bodily illness followed by improvement in the mental symptoms. Very often phthisical patients became rational before they died.

Case of Sudden Death during Feeding by the Stomach Pump.—Dr. YELLOWLEES informed the meeting that he had lately had a case of sudden spasmodic syncope terminating fatally during feeding with the stomach pump. This led to a discussion on the relative merits of the nasal and the œsophageal modes of forcible feeding. The general opinion of the meeting was that if a patient can be as easily fed by the mouth, the œsophageal mode was preferable, but where there was much difficulty, the nasal was to be preferred. The importance of allowing a little water to flow through the tube into the stomach before the feed was insisted on, and had been pursued in Dr. Yellowlees' case. The best nasal tubes are made of red rubber, and should be greased with a solution of castile soap instead of oil, which acts chemically upon the rubber. Nasal feeding has also sometimes a good moral effect on the patient.

Handbook of Instructions for Attendants on the Insane.—Dr. CLOUSTON moved, that this meeting having received the proof and copy of the "Handbook for the Instruction of Attendants on the Insane," thank their Sub-Committee for the great trouble they have taken in this matter, and for the way in which they have done their work; and that the members present request the Sub-Committee to print off a thousand copies for sale, and agree to defray all expenses.

This was seconded by Dr. RUTHERFORD, and unanimously agreed to.

Date of Quarterly Meetings.—Dr. YELLOWLEES moved that the meetings of the Northern Section of the Association be held hereafter on the second Thursdays of March and November, which was agreed to.

Dr. Rutherford exhibited plans of proposed additions to the Second House of the Crichton Royal Institution, which elicited opinions as to the best mode of extending such asylum buildings.

BRITISH MEDICAL ASSOCIATION, BELFAST, JULY AND AUGUST, 1884.

(SECTION OF PSYCHOLOGY.)*

Dr. TUKE read a paper on "Moral Insanity." Dr. Tuke briefly summarised the cases sent to the "Journal of Mental Science" on Moral Insanity, and after detailing some of his own, grouped them under various heads, principally the congenital and acquired, the impulsive and non-impulsive, and those associated with epilepsy and drink. He considered that clinical facts established the existence of a morbid mental condition to which the name of moral insanity might be applied; but the term was unfortunate, if it led to the supposition that the moral sentiments were themselves always the seat of disease instead of the higher controlling centres, although in one group of cases the altruistic sentiments might be themselves the seat of derangement. The rest of the paper was devoted to a consideration of the metaphysical difficulties which arise, if the doctrine of moral insanity is held, and Herbert Spencer was quoted to show that it was not necessarily irreconcilable with mental evolution, and the intimate alliance between cognitions and emotions. (Original Articles).

The PRESIDENT OF THE SECTION (Dr. Savage) said there certainly was a group of mental diseases deserving the name "Moral Insanity." There were arrests of development so that the subjects of it were not of the proper social standard, and there were cases in which decay is most marked in loss of

* We are indebted for these notes to the Secretary of the Section, Dr. Rees Phillips.

self-control. There were two classes of hysteria, one the Rossetti-like women, who, like the grave, seem ever hungry; and the second, women who were gross, fat, and sensual looking. There were two similar classes of morally insane. In some cases there is perversion at puberty just at the time of the addition of this new vital force—a great force added to life, and not controlling power with it. In one lady I received a description, saying that at puberty she began to develop lying, thieving, and lust; the lying and thieving were objectless. In other cases there is mathematical or musical power, or wonderful power of memory specially marked by small details, though morally insane. In one case a lad with special powers was decided on inquisition to be sane, and in a day was brought before the magistrates for indecent assault, and was sent to prison.

Dr. DEAS remarked that though we should all be agreed as to the existence of cases where the perversion or impairment of the so-called moral faculties is so marked, along with the absence of any decided symptoms of intellectual impairment, as to justify their being classed under some such term as moral insanity—still he was strongly inclined to the belief that in almost all such cases some evidences of intellectual impairment will be discovered if the mental condition is carefully probed; and Dr. Tuke's emphasising the view that in many cases the moral faculties themselves are not so much diseased as the higher centres by which the lower propensities are as a rule controlled, points in this direction. Even in cases of apparently congenital want of development of the moral faculties, of which a striking example was quoted, there will often be found some intellectual defect as well. In connection with Dr. Tuke's remarks on the impulsive nature of many cases of moral insanity, and their relation to epilepsy, he mentioned a remarkable case of impulsive homicidal insanity, in which, without any epileptic seizures, there was a distinct subjective aura before the outset of the homicidal attacks, with a loss of consciousness as far as the patient having no recollection of the attack is concerned. He also alluded to certain cases of doubtfully spurious insanity, associated with great moral perversion, and a propensity to obtain admission into one asylum after another, which may almost be considered a special form of moral insanity.

Dr. REES PHILLIPS said that Dr. Deas' interesting remarks on Dr. Tuke's able paper led him to mention a case which had been under his care, and was now under that of Dr. Deas. Dr. Deas considered that in nearly all cases of moral insanity there was mental impairment; but that was not apparently the opinion of the Commissioners in Lunacy. The case he referred to was that of a middle-aged lady, who from early girlhood showed marked erotic tendency, and was given to indecent assaults, but who was discharged on the recommendation of the Commissioners in Lunacy. The Commissioners, although informed that the lady had, within a few days of the interview with them which led them to consider her fit for discharge, indecently assaulted a young gentleman patient, said that they were not censors of morals, but had only to judge of mental status! After her discharge the lady led a flagrantly improper life. She became quite a nuisance in the seaside town in which she resided. In the end she had to be re-certified and re-admitted into Wonford House, and although the certificates were weak from the intellectual standpoint, they were accepted by the Commissioners in Lunacy.

Dr. YELLOWLEES thought that, referring strictly to the moral insanity of which Dr. Tuke had spoken, it was invariably the result of hereditary tendency, and associated with other forms of neurotic disorder among the relatives. In the individual the perversion is usually congenital, or associated with arrested development. The condition differs from the impulsive explosions which occur in epileptics replacing the convulsions, for in these the patient has no recollections of the explosions. It is also quite different from the impulsive tendencies occurring in coarse brain disease, or from the prurient manifestations sometimes seen in old age. The proof that this moral insanity is the result of a brain condition is that such patients are found, when the full history is known, to die from brain disease. In the treatment of such cases, punishment is utterly and hopelessly futile, but they are most unwelcome inmates of an asylum. In the

worst cases, and chiefly for the sake of others, the passive restraint of a prison seems the only recourse. He did not agree with the view that such cases were merely imperfectly civilized beings, who would have been deemed sane if judged by the lower standard of morality and propriety prevalent some hundreds of years ago. The mental pathology of such cases is defective inhibition from a loss of regulating and controlling power in the highest centres. To use Dr. Tuke's illustration, "The horses ran off with the coach because the driver had let go the reins." But there are many cases where this theory does not seem to suffice, and where the morbid perversion of the emotions seems the primary and essential condition, or to continue the same illustration—where the horses bolt and run off with the coach in spite of all the driver can do.

Dr. WIGLESWORTH said he wished to express the pleasure he experienced in listening to Dr. Tuke's address, and his entire agreement with the line of argument with which the subject had been approached. Without doubt the moral sense is the latest acquirement of civilization, and one of the first to be lost. Moral sense is indeed a necessary consequence of the development of civilization, for men cannot live together in communication without the development of some such sense. There is undoubtedly, as Dr. Tuke had pointed out, a psychological difficulty. Feeling being primordial, and intellect having been developed out of it, it might be expected that intellect ought to give way first; but probably the intellect is in some cases not so totally unaffected as has been thought, the higher qualities of volition and attention being deficient, whilst the more automatic qualities may be well developed. He had seen cases in which the intellect was of a low grade, though they were not insane intellectually. He would like to emphasize the fact that the morally insane individual may be insane only as regards the present state of society. At an earlier period in the development of the race, his undeveloped moral nature would not, in a sense, have constituted lunacy. An important question is, what is to be done with these cases? They are the curse of every asylum to which they are sent, and in his (Dr. Wiglesworth's) opinion, an asylum is not the place for them, but rather the prison. It was no use appealing to higher sentiments of which they were destitute, and one must use as treatment a method which they can understand.

Dr. CONOLLY NORMAN said that three cases which he had noted in this connection were very interesting. In one there was, however, really aberration with dominating delusions, which were for years concealed, during all this time the only sign of alienation being profound change in moral and social sentiments. In two other cases there was true moral insanity or imbecility of the congenital type. Those patients were morally insane, nevertheless; both patients having got into trouble through immoral acts, simulated acute attacks of insanity, and thus obtained admission to asylums, though till then the nature of their real ailment had not been detected. That the insane may simulate insanity must be admitted.

Dr. TUKE, in reply, admitted that very careful examination of a patient would often detect some intellectual disorder; but the difficulty often was that, when found, it was not of a character which was admitted legally as evidence of insanity or irresponsibility, as, for instance, an inferior grade of intellect. It had been said that the will itself is an intellectual function, and that as it is held that volitional power is lost in moral insanity, the contention in favour of the latter falls to the ground. This resolved itself into a question of terms, and if it is preferred to comprise volition under intellect, and the law will admit that loss of control is sufficient proof of intellectual aberration, the same goal will be reached as by the ordinary presentment of moral insanity. He objected to the confinement of such cases in prison. If there was, as he held, cerebral disease or defect, though not intellectual derangement, they must be treated as insane persons. This was the logical conclusion of his paper.

INTERNATIONAL HEALTH EXHIBITION, LONDON, 1884.

In a former number of the Journal notice was taken of a paper read before the Health Exhibition by Dr. Shuttleworth. Another paper was read at the Conference held on August 1st, 1884, on a cognate subject by Dr. Fletcher Beach, the medical superintendent of the Darenth asylum. It bears the title of "Facts Concerning Idiocy and Imbecility," and contains a clear *resumé* of the provision hitherto made for the weak-minded; the symptoms and the general treatment of idiocy and imbecility. Adapted for a lay audience, it is not needful to refer further to Dr. Beach's remarks, except so far as they are historical. It may be a convenience to the readers of the Journal to have the main events extracted, and placed in a clear form for reference:—

Interest excited by the savage of Aveyron, whom M. Itard endeavoured to educate in Paris.

M. Ferrus organized an idiot school at the Bicêtre in 1828, the parent of those that have been established since at home and abroad.

M. Falret established a school for female idiots at the Salpêtrière.

MM. Voisin and Leuret, physicians to the Bicêtre, established idiot schools in that asylum.

Dr. E. Segnin taught in the Bicêtre school, and by various pamphlets made known his mode of teaching to the world.

Dr. Guggenbühl, in 1842, opened his school for cretinous idiots on the Abendburg, near Interlachen.

At the same period Herr Sægert opened a school for idiots in Berlin.

Dr. Kerlin, in 1846, established a school at Leipzig.

In the same year Dr. H. B. Wilbur opened a school for idiots at Barre, Massachusetts, which he afterwards left to conduct a school at Albany, New York State.

In the same year, also, Dr. Howe opened a school at Boston, Mass.

In England, at the same time, Miss White established a small institution for idiots at Bath, the first of the kind in this country.

In 1848 the next asylum was opened at Park House, Highgate, by Mrs. Plumbe and Dr. Andrew Reed.

The latter asylum was developed into the Earlswood asylum for idiots, at Redhill, Surrey. Dr. Down, formerly the superintendent, established, on leaving, the private institution at Normansfield, Hampton Wick.

In 1850 Essex Hall, at Colchester, was opened as a branch of the institution at Highgate, and is now the idiot asylum for the Eastern Counties.

In 1864 the idiot asylum for the Western Counties was established.

In 1866 the Midland Counties' institution for idiots was opened.

In Scotland two asylums for idiots had been established in 1863: one at Baldovan, Dundee; the other at Larbert, near Falkirk; Dr. Brodie being the superintendent of the former, and Dr. Ireland of the latter.

In Ireland, in 1870, an attempt was made to provide for this class. Dr. Stewart, of Dublin, contributed a handsome sum to the purpose, and the Stewart institute came ultimately into operation at Palmerston.

In 1870 the Royal Albert asylum for idiots and imbeciles for the Northern Counties was opened at Lancaster, under Dr. Shuttleworth.

In 1875 the first pauper school for idiots was opened at Clapham, London, under Dr. Beach.

In 1878 the patients were removed to the new and much larger school at Darenth, Kent, and remain under the same superintendent.

There are at the present time, according to Dr. Beach, 30,000 idiots and imbeciles in England and Wales. The provision made falls very far short of the requirements of this class, and more institutions should be erected, quite apart from the question of restoration to mental power. Should they only prove to be custodial, they are required for the comfort alike of the children and their families, in which they are a terrible burden. It is needless to say in this place that county asylums are not the proper receptacles for this class.

OPENING OF THE HOLLOWAY SANATORIUM.

On June 15th the long-expected opening of this hospital for the insane took place. Mr. Martin-Holloway delivered a short address, to which the Prince of Wales replied, and declared the asylum to be open. The corridors and rooms are profusely decorated in accordance with the somewhat curiously-worded intention of "endeavouring above all things to avoid leaving a dimmed intelligence opposite a blank wall." It is unfortunate that this praiseworthy intention necessarily falls to the ground in the single rooms for refractory patients; indeed, it will be needful to make their walls a little barer still if accidents are to be avoided. We wish Dr. Sutherland Rees Philipps the success he merits in his new and responsible post as medical superintendent. The late Mr. Thomas Holloway has certainly devoted his money to a good object. The only fear we entertain is that if the institution is not, as we understand, endowed, the institution will become a private asylum for the higher classes with a very few inmates of the class for which, no doubt, the donor intended it. We shall see whether it succeeds in avoiding the charges brought against similar institutions in England.

LORD SHAFTESBURY.

It will have afforded sincere satisfaction to all interested in the insane to hear that, in consequence of the Lunacy Bill having been withdrawn, the Earl of Shaftesbury has consented to return to his post as Chairman of the Board of Commissioners in Lunacy. We do not regret having had an opportunity afforded us of expressing in the "Occasional Notes of the Quarter" the feeling universally entertained in our department in regard to the services rendered by Lord Shaftesbury, although the article is no longer applicable to the present state of affairs. The address to his Lordship which it was intended to propose at the Annual Meeting will, of course, not be proceeded with, but his Lordship will have the satisfaction of knowing how much the Medico-Psychological Association appreciates his work on behalf of the insane.

ABSTRACT OF LUNACY ACTS AMENDMENT BILL.

[Although, in consequence of recent political events, the proposed Lunacy Bill will not pass into law this session, it is thought that the following abstract of the Bill, as amended in Committee, will be of service for reference in future.]

The principal objects of this Bill are—

I. To furnish safeguards against the improper confinement of persons as lunatics.

II. To give facilities for the medical treatment of persons who desire to submit to treatment, and of idiot and imbecile children.

III. To enable public asylums to be provided for the reception of lunatics not paupers.

IV. To give increased powers to the Court for administering the property of lunatics.

V. To make certain amendments in detail, with a view to a consolidation of the Lunacy Acts.

The Bill adopts in the main the recommendations made by the Report of the Select Committee on Lunacy Law in the year 1878.

[In this abstract the following abbreviations are used :—

(a) Judge, &c., *instead of* judge of county courts, stipendiary magistrate, or justice of the peace.

(b) Superintendent, &c., *instead of* superintendent or proprietor of any asylum, hospital, or house, or any person having charge of a single patient.

(c) Asylum, &c., *instead of* asylum, hospital, or house.]

(Clause 1.)

This Act may be cited as the Lunacy Acts Amendment Act, 1885, and shall come into operation on January 1st, 1886 ; except as in this Act otherwise provided, it shall not extend to Scotland or Ireland.

(Clauses 70 and 72.)

This Act shall be construed as one with 8 and 9 Vict., c. 100, and 16 and 17 Vict., c. 97, and the Acts amending those Acts respectively.

Nothing in this Act shall affect the provisions of the Criminal Lunatics Act, 1884, or of any other Act relating to criminal lunatics.

(Clause 2.)

For the purposes of making “ orders for the reception of private patients,” justices of the peace are to be appointed in every county or borough at the Michaelmas General or Quarter Sessions in 1885, and every succeeding year.

These appointments rest with the justices themselves, who are responsible for the selection out of their own body of as many fit and proper persons as may be necessary, regard being had (in the case of each county) to the convenience of each petty sessional division.

[Only those justices of the peace who are thus specially appointed have the power to make orders for the reception of *private* patients. Any justice may make an order for the reception of a pauper patient.]

A. In addition to general provisions with regard to the admission of private patients, and of paupers, there are special provisions with regard to

Lunatics not under proper control ;

Lunatics dangerous to public order ;

Removal to workhouse in cases of urgency ;

Detention in workhouses (temporary or otherwise) ;

Single patients ;

Boarders ;

Idiots and imbeciles.

In the case of private patients, different processes are provided for ordinary cases, and cases of urgency.

Provisions concerning the Admission of Ordinary Private Patients.

(Clause 3.)

No ordinary private patient may be received as a patient into any asylum, &c., or as a single patient, without an "order for reception" given by a county court judge, stipendiary magistrate, or justice of the peace having jurisdiction in the place where the lunatic is.

To obtain such an order, private application by petition shall be made, the petition being accompanied by a statement of particulars, and by two medical certificates on separate sheets of paper.

The petition shall, if possible, be presented by the husband or wife or by a relative of the alleged lunatic. If not so presented, the petition shall contain a statement—

(a) Of the reason why it is not so presented;

(b) Of the connexion of the petitioner with the alleged lunatic, and the circumstances in which he presents the petition.

The petitioner must be more than 21 years old; and must have personally seen the patient within 14 days before the presentation of the petition. He must undertake that he will, either personally or by deputy (specially appointed by himself), visit the patient at least once in every six months.

(For form of petition and statement see Forms 1 and 2 in the Schedule.)

The two medical certificates* must be under the hands of two duly qualified and registered medical practitioners in actual practice; one of whom must, whenever practicable, be the usual medical attendant of the patient. (If the patient has already been received under an urgency order, the medical practitioner who signed the urgency medical certificate may not sign either of the medical certificates accompanying the petition.) Each of the two must, separately from any other practitioner, personally examine the patient not more than seven clear days before the presentation of the petition.†

(For form of medical certificate, see Forms 6 and 7 in the Schedule.)

If for any reason it is not practicable to obtain a certificate from the usual medical attendant, such reason must be stated in writing by the petitioner.

It is permissible for the certifying medical practitioners to meet in consultation "at any time or place before the signature" of the certificates.

A medical practitioner who signs a certificate of insanity according to this Act, and with good faith, shall not be liable to any civil or criminal proceeding for signing the certificate, or for any act done with the view of enabling him to sign it.

* For "persons disqualified from signing medical certificates and orders," and for "amendment of orders and certificates," see pages 294, 295.

† Note that urgency certificates are in force only three days from the date of examination.

If, on presentation of a petition, the judge, &c., is satisfied with the evidence of lunacy appearing by the medical certificates, he may forthwith make an order for the reception of the patient. Or he may fix as early a day as possible, not more than seven days after the presentation of the petition, for the consideration thereof; notice of time and place of consideration being given to the petitioner personally, or sent by post.

If the justice wishes, he may call for the assistance of the clerk of the petty sessional division in which he is acting; the clerk's fee of 1s. 6d. to be paid by the petitioner.

The petition is to be considered in private; without the permission of the judge, &c., no one is to be present but the petitioner and the certifying medical practitioners. All who are present at the consideration of the petition (including the judge, &c.), and all having official cognizance that a petition has been presented, are bound to secrecy, except when required to divulge any matter by lawful authority.

If the judge, &c., is not satisfied with the evidence of insanity given in the medical certificates, he may make any further enquiries he may think fit, and may take evidence on oath. Also, if he shall think it necessary, he *may* visit the alleged lunatic.

On the day fixed for considering the petition the judge, &c., may make an order, or may dismiss the petition; or he may adjourn for more evidence or information, and may summon any person to attend before him at the adjourned consideration.

If the petition is dismissed, the judge, &c., is to give to the petitioner a written statement of reasons for such dismissal.

An order for the reception of a private patient, purporting to be signed by a judge, &c., shall be sufficient authority for *taking such patient, conveying him to the place mentioned in the order*, and detaining him there, without further evidence of the signature.

The order is available (as heretofore) for the space of one calendar month from date of signature.

(For form of order, see Form 3 in the Schedule.)

The order, petition, statement, and medical certificates are to be delivered to the petitioner, and by him to the superintendent, &c., by whom the patient is to be received. Within 24 hours from the reception of the patient, copies of all these documents are to be sent to the Commissioners.

The position occupied by a successful petitioner, as regards his powers over and liabilities to the lunatic, is the same as that heretofore occupied by the person signing the order.

Power to Appoint Substitute for the Person who signed the Order or Petition.

(Clause 28.)

The Commissioners may by order substitute for the person who signed the order or petition for the reception of a private patient, any

other person willing to undertake the duties and responsibilities. From the date of the Commissioners' order the substituted person undertakes all the liabilities, and may exercise all the powers of the person for whom he is substituted ; but the latter is not released from any liabilities already incurred by him.

An order under this section may be made with or without the consent of the person who signed or obtained the order for the reception ; but in the latter case no order may be made until 14 days after notice has been given by the Commissioners to the person proposed to be substituted ; this person may, either in person, or by written statement, lay before the Commissioners his reasons why such an order should not be made. The Commissioners finally make or decline to make the order, as they think fit.

Provisions concerning the Admission of Private Patients in case of Urgency.

(Clause 4.)

In case of urgency, where it is desirable to place the patient (not being a pauper) at once under care and treatment, the patient may be received upon an urgency order, with one medical certificate.

The urgency order is to be signed (if possible) by the husband or wife, or by a relative of the lunatic.*

If not so signed, it must be stated why not ; and also what connexion the person signing the order has with the patient, and the circumstances under which he signs. No one may sign an urgency order unless he is over 21, and unless he has seen the patient within seven days before the date of the order.

One medical certificate is to be given, signed by a duly qualified medical man, who must have personally examined the patient not more than three clear days before his reception.

(For forms of urgency order and medical certificate, see Forms 4, 6, and 7 in the Schedule.)

The urgency order may be signed before or after the medical certificate. It remains in force for seven days, but if a petition be pending (as previously described), then for such further time as the judge, &c., may direct in writing. Pending the consideration of the petition, the urgency order may be thus extended again and again by the judge, &c. Every order for such extension is to be delivered to the petitioner or his authorised representative, for transmission to the superintendent, &c., in charge of the patient.

The urgency order is to be sufficient authority for taking the patient and conveying him to the place mentioned therein, and for his reception and detention.

* This order being equivalent to that of the judge, &c., together with the petition in ordinary cases.

The superintendent, &c., of any asylum, &c., into which any patient is received on an urgency order, is "*forthwith*," after such reception, to send a copy of the urgency order and medical certificate to the Commissioners; and he is also to send to the Commissioners a copy of every order (if such be made) enlarging the time during which the urgency order is in force.

If necessary, an urgency order may be made *subsequent* to the presentation of a petition in the ordinary form.

[There should be no unnecessary delay, after the making of an urgency order, in presenting a petition for the making of an order by a judge, &c., in the ordinary way.]

16 and 17 Vict., c. 96, s. 5, which provided that in certain cases a patient might be received on a single medical certificate, is repealed.

*Provisions concerning Lunatics not under Proper Control or Care,
and Cruelly Treated or Neglected.*

(Clause 5.)

For the protection of the above (not being paupers and not wandering at large), Clause 5 provides as follows :—

Every constable, relieving officer, or overseer who has knowledge that within his district or parish any person deemed to be a lunatic is not under proper care or control, or is neglected or cruelly treated, is within three days of obtaining such knowledge to give information on oath to a justice.

The justice, on receiving such information on oath from a constable, relieving officer, or overseer, or from any person whomsoever, is to choose and authorise any two qualified medical practitioners to visit and examine the alleged lunatic, and report upon his mental state. After which the justice is to proceed as far as possible in the same manner as if a petition had been presented in the usual way. If he is satisfied, from the two medical certificates, and his own inquiry, that the alleged lunatic is a lunatic and is neglected, cruelly treated, or not properly cared for, and that he is a proper person to be taken charge of, and detained under care and treatment, he may make an order (see Form 16* in Schedule) committing the lunatic to any asylum, &c., to which he might be sent under the Lunatic Asylums Act of 1853. The lunatic is to be conveyed to the asylum by the constable, relieving officer, or overseer who gave the information, or by any constable appointed by the justice.

The execution of this order may be suspended, if the justice thinks fit, for any period not exceeding 14 days; during which period the lunatic is cared for as the justice may direct.

If either of the two examining medical practitioners certifies in writing that the lunatic is not in a fit state to be removed, execution of the order shall be suspended till the same or some other medical practitioner certifies in writing that he is fit to be removed.

Any relation or friend of the lunatic who can show satisfactorily that for the future the lunatic will be properly cared for may retain or take charge of him, even though an order as above has been made, and acted upon.

* No such form appears in the schedule as printed.

Provisions concerning Lunatics Dangerous to Public Order.

(Clause 10.)

If a lunatic is apprehended charged with any offence, or if he is dangerous or a public nuisance, a county court judge, stipendiary magistrate, or any J.P. having jurisdiction in the place where the lunatic is, may (upon application by a relieving officer or any other person, accompanied by a certificate from a duly qualified medical practitioner stating that the lunatic is dangerous or offensive) commit the lunatic to custody. The judge, &c., is then, by advertisement in a local newspaper, to give notice of the committal, and that an enquiry into the lunatic's condition will be held at a time and place named. Unless within 24 hours after such notice the relieving officer of the union in which the lunatic was found gives a satisfactory undertaking to make arrangements for the custody of the lunatic, the judge, &c., shall proceed to make enquiry into the patient's condition; and if he be satisfied that the lunatic is dangerous or offensive, he shall make an order for his committal to "any asylum;" and such order shall be sufficient authority for his committal.

The judge, &c., may make an order upon the guardians of the union in which the lunatic was found for payment of the fee of the certifying medical practitioner, and of all the expenses of the enquiry; and also for payment of the charges for the lunatic's maintenance in the asylum.

The guardians have the same rights as heretofore for recovery of any sums paid under such an order.

Persons disqualified from signing Medical Certificates or Orders.

(Clauses 6 and 7.)

The following persons are disqualified from signing medical certificates, whether accompanying an urgency order, or a petition for an ordinary order:—

(a) The petitioner, or the person signing the urgency order; and the husband or wife, father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, partner or assistant, of such petitioner or person.

(b) Any person interested in the asylum, hospital, or house, in which the patient is to be received; such as the superintendent or proprietor, or any regular medical attendant in the asylum, &c.; any person interested in the payments on account of the patient; and the husband or wife, father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, partner or assistant, of any of the foregoing persons.

(c) Neither of the two certifying medical practitioners shall be the father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, partner or assistant, of the other.

No member of the governing body of a hospital may apply for an order, or sign a certificate, for the admission of a lunatic into that hospital.

Any superintendent, &c., who knowingly receives a patient on an

order or certificate signed by disqualified persons, shall be guilty of a misdemeanor.

Amendment of Orders and Certificates.

(Clause 17.)

The power to amend orders and certificates, given by 16 & 17 Vict., c. 96, s. 11, may be as heretofore exercised, by and with the consent of the judge, &c., by whom any order for the reception of a lunatic may have been signed.

The provisions of 8 & 9 Vict., c. 100, and 16 & 17 Vict., c. 97, and the Amending Acts shall, except where modified by this Act, apply to orders and medical certificates under this Act (Clause 18).

Wilful Misstatement.

(Clause 16.)

Any person making a wilful misstatement of any material fact in any petition, statement of particulars, or order for the reception of a private or pauper patient, or in any medical or other certificate, under Acts 8 & 9 Vict., c. 100, 16 & 17 Vict., c. 97, or the Amending Acts, or under this Act, shall be guilty of a misdemeanor.

No prosecution for misdemeanor under this section shall take place except by the direction of the Attorney General or the Public Prosecutor.

Provisions concerning the Admission of Pauper Patients

(to an asylum, &c.)

(Clause 11.)

After the passing of this Act no pauper is to be received as a patient into any asylum, &c., under an order under the hands of an "officiating clergyman" and overseer or relieving officer.

No justice of the peace shall sign an order for the reception of a pauper lunatic into any asylum, &c., or workhouse, unless he is satisfied that the alleged pauper is either in receipt of relief or in such needy circumstances as to require relief. A person visited by a medical officer of a union at the expense of the union is to be regarded as in receipt of relief.

The order of a justice for the reception of a pauper lunatic into any asylum, &c., may be made on the certificate of any duly qualified medical practitioner. (See Forms 10 and 6 in Schedule.)

Provisions for Removal to Workhouse in cases of Urgency.

(Clause 12.)

Where a constable, relieving officer, or overseer has knowledge that within his district or parish there is an alleged lunatic for whose immediate care relief appears necessary, if he is satisfied that it is urgently

necessary that the alleged lunatic should (either for his own or the public welfare and safety) be "forthwith" placed under care and treatment, the constable, &c., may remove the alleged lunatic to the workhouse of the union in which the alleged lunatic is; and the master of the workhouse shall receive and detain the alleged lunatic, unless there is no proper accommodation for him in the workhouse. But no person is to be so detained for more than 48 hours, unless meanwhile the provisions of this Act relating to the detention of lunatics in workhouses have been complied with.

Provisions concerning the Temporary Detention of a Lunatic in a Workhouse.

(Clause 13.)

Where, under the Lunatic Asylums Act, 1853, any justice receives notice, or information on oath

(a) That a pauper resident within his jurisdiction is an alleged lunatic; or

(b) That any person (whether proved to be a pauper or not), wandering at large within his jurisdiction is an alleged lunatic; if such justice is satisfied that it is expedient that the alleged lunatic (for his own or the public welfare) should be forthwith placed under care and treatment, he may make an order for taking the alleged lunatic and receiving him in the workhouse of the union in which the alleged lunatic is, if, in the justice's opinion, there is proper accommodation for him there.

Such an order shall authorise the detention of the lunatic for not more than 7 days from its date; after which no further detention is lawful, unless authorised in the manner provided in the following section:—

No person is to be received in a workhouse as a lunatic except in the way indicated in this section or the one immediately preceding. If the master of a workhouse receives any person as a lunatic in a workhouse except as above provided he shall be guilty of a misdemeanor.

Provisions concerning the Detention of Lunatics in Workhouses.

(Clause 14.)

Except as before provided, no person is to be detained in a workhouse as a lunatic unless the medical officer of the workhouse certifies in writing—

(a) That such person is a lunatic; with grounds for the opinion;

(b) That he is a proper person to be kept in a workhouse as a lunatic;

(c) That there is suitable accommodation for him in the workhouse.

(For form of certificate see Form 8 in Schedule.)

This certificate authorises the detention of a person as a lunatic in the workhouse for 14 days from its date; but for no longer, unless an

order (see Form 9 in Schedule) is obtained from a justice of the peace having jurisdiction in the place where the workhouse is situate. To obtain this order, the relieving officer of the union to which the workhouse belongs must make application, supported by a medical certificate (Form 6 in Schedule) given by a duly qualified medical practitioner who is not an officer of the workhouse, and also by the certificate (Form 8 in Schedule) given by the medical officer of the workhouse.

The guardians are to remunerate the medical practitioner who, not being an officer of the workhouse, "examines a person for the purpose of a certificate."

If, in the case of an alleged lunatic in a workhouse, the medical officer shall not sign the certificate required as above; or if within 14 days from the date of such certificate no order is made by a justice for the detention of the lunatic, the medical officer of the workhouse shall "forthwith" give written notice to a relieving officer of the union that a pauper in the workhouse is deemed to be a lunatic and a proper person to be sent to an asylum; thereupon such proceedings are to be taken by the relieving officer, &c., for the purpose of removing the lunatic to an asylum, as are provided in the case of a pauper deemed to be a lunatic and a proper person to be sent to an asylum. The removal is to be effected within the same time as by the Lunatic Asylums Act, 1853.

If the medical officer of the workhouse omits to give such notice to the relieving officer, he shall for each day or part of a day after the first and before the notice is given during which the lunatic remains in the workhouse, forfeit any sum not exceeding £10.

If the relieving officer fails to perform his duty he shall for each offence forfeit any sum not exceeding £10.

25 & 26 Vict., c. 111, s. 20, which provided for the detention of lunatics in workhouses, is repealed.

Notice to be given of Change of Classification of Patient.

(Clause 19.)

Where a pauper patient in an asylum, &c., is afterwards classified as a private patient, or *vice-versâ*, notice of the change of classification is to be sent within 3 days by the superintendent, &c., to the Commissioners, and, in the case of a house licensed by justices, also to the Clerk of the Visitors.

For each day during which default in sending such notice continues, the Superintendent, &c., shall forfeit 40 shillings.

Provisions concerning Single Patients.

(Clauses 24, 25, 26.)

Any two Commissioners may direct that the medical attendant of a single patient shall cease to act, and be replaced by some other

person. If the person having charge of the patient fails to carry out this order, he shall be guilty of a misdemeanor.

One or more of the Commissioners shall at least once a year visit every unlicensed house in which is a single patient, and shall report to the Commissioners on the treatment and condition of the patient. On each visit every part of the house and grounds may be inspected; if the person in charge of the patient refuses to show to the Commissioners any part of the house or grounds, he shall be guilty of a misdemeanor.

Any two Commissioners (one a physician, the other a barrister) may, after one visit, and not later than two days thereafter, order the discharge of anyone detained as a single patient, with the like consequences as follow an order by the Lord Chancellor for the discharge of a single patient under 16 and 17 Viet., c. 96, s. 18.

When anyone having charge of a single patient dies the Commissioners may, on the application of the person having authority to discharge the patient, or (if he does not apply within seven days after the death) on their own motion, by order direct the patient to be transferred to the charge of the person named in the order.

The Commissioners, or any two of them, may order the removal of a lunatic from the charge of anyone having care of him as a single patient.

Provisions concerning Boarders. -

(Clause 30.)

The superintendent or proprietor of any hospital or licensed house may, with the previous consent in writing of two Commissioners, receive into the hospital or house as a boarder, for the time specified in the consent, anyone desiring voluntarily to submit to treatment; at the end of which time (unless extended by further consent) he shall be discharged.

The Commissioners' consent shall be given only on application by the intending boarder. (Form 12 in Schedule.)

Every boarder shall, if required, be produced to the Commissioners and visitors on their respective visits.

A boarder may leave on giving to the superintendent or proprietor 24 hours' notice of his intention. If at the end of the 24 hours' notice he is not allowed to leave, he shall be entitled to recover from the superintendent or proprietor £10 as liquidated damages for each day or part of a day during which he is detained.

The superintendent or proprietor shall, within 24 hours after the admission of a boarder, send to the Commissioners notice of such admission in Form 13 in the Schedule; and within three days after the discharge of a boarder shall send to the Commissioners notice of discharge in Form 14 in the Schedule. In default of sending either of these notices he shall for each offence forfeit a sum not exceeding £20.

Provisions concerning Idiot and Imbecile Patients.

(Clauses 33, 34, 35.)

An idiot or imbecile may, if under age, be lawfully placed and received in any public or charitable institution for the care or training of idiots or imbeciles, and detained therein till of full age, upon a certificate (see Form 15 in Schedule) of a duly qualified medical practitioner that the patient is an idiot or imbecile, capable of receiving benefit from such institution.

One so received while under age may, with the consent of the Commissioners, be retained in the institution *after* he is of full age ; and an idiot or imbecile may, with the like consent, be received in an institution after he is of full age, upon a certificate in Form 15.

The Commissioners may at any time order the discharge of any person of full age retained under this section.

The superintendent or principal officer of every institution in which idiots or imbeciles are intended to be received shall apply to the Commissioners to have the institution registered, and the Commissioners, if satisfied that it is proper, may issue a certificate of registration accordingly ; and no idiot or imbecile is to be received into any institution until it has been duly registered.

Any hospital or public or charitable institution which, at the passing of this Act, is devoted exclusively to the care, &c., of idiots or imbeciles may be registered.

When any idiot or imbecile is admitted into a registered institution the superintendent or principal officer shall certify in writing to the Commissioners the fact and time of his reception, specifying his name and age, and the names and addresses of the persons placing him in the institution, and that he is alleged to be capable of receiving benefit.

The Commissioners may, whenever they think fit, visit (with full powers) any such registered institution and all persons under care therein.

None of the provisions of this Act (or other Lunacy Acts) relating to *lunatics* shall apply to any institution or hospital registered under this section, or to any idiot or imbecile received therein.

A medical journal shall be kept in institutions registered under this section in such form as the Commissioners may direct.

In the case of any licensed house (not being a public or charitable institution) used solely for idiots and imbeciles, the Commissioners may, under their seal, dispense, during such time and to such extent as they think fit, with the observance of all or any of the provisions of this or any other Act from which public or charitable institutions registered as above are exempted, which they may deem to be unnecessary in the case of such licensed house.

In the case of an institution, hospital, or licensed house established or licensed solely for the reception of idiot and imbecile infants labouring under congenital imbecility, the Commissioners may by order dispense with the residence of a medical practitioner.

B. The following provisions are of importance subsequent to the admission of a patient, until and including his removal or discharge :—

Statement required after Admission.

(Clause 20.)

After two clear days, and before the expiration of seven clear days from the day of reception (into an asylum, &c., or as a single patient) of any patient (whether private or pauper), the statement of condition must be sent as heretofore. In this statement it must be certified whether or not there are any marks of violent or improper treatment on the patient's body.

Report (in addition to above Statement) required for Private Patients.

In the case of *private* patients, at the expiration of one calendar month from the reception of the patient the medical officer or attendant of every asylum, &c., and of every single patient, shall send to the Commissioners a report as to the mental and bodily condition of the patient; and in the case of a house licensed by justices a copy of such report is also to be sent to the Clerk of the Visitors.

Visitation of Patients.

After this report the (private) patient is to be visited as soon as practicable :

(a) In the case of a patient in a hospital or licensed house within their immediate jurisdiction, by one or more of the Commissioners ;

(b) In the case of a patient in a hospital not within their immediate jurisdiction, by one or more of the Commissioners, or by the medical visitor * of licensed houses in the county or borough wherein such hospital is situate ;

(c) In the case of a patient in a licensed house not within the Commissioners' immediate jurisdiction, by the medical visitor (either alone or with one or more of the other visitors) ;

(d) In the case of a single patient, by one or more of the Commissioners, or (if the Commissioners so direct) by a medical visitor for the county or borough in which the single patient resides, or by some other competent person appointed by the Commissioners ;

(e) In the case of a private patient in an asylum, by one or more of the Commissioners, or (if the Commissioners so arrange) by one or more members of the Committee of Visitors of the asylum.

To whom Report of Visitation is to be Sent.

In the case of a private patient in an asylum being visited by one or more members of the Asylum Committee of Visitors, these visitors

* " Medical visitor " here, and wherever subsequently used, means the medical visitor as appointed by the justices under 8 and 9 Viet., c. 100, s. 17.

are to report to the Committee whether the patient's detention is or is not proper; and the Committee, or any three of them, may then order the patient's discharge, or give such directions as they consider necessary.

In all other cases the visitor (whether Commissioner, medical visitor or visitors, or specially-appointed visitor) is to report to the Board of Commissioners whether the patient's detention is or is not proper; and the Commissioners may then, if they think fit, make an order under their seal for the patient's discharge.

Any medical visitor or other competent person directed by the Commissioners to visit a single patient is to have all the powers of a Commissioner, and is to receive reasonable remuneration from the Board of Commissioners.

Letters of Patients.

(Clause 37.)

The superintendent, &c., of every asylum, &c., and the person in charge of a single patient, must forward unopened all letters written by patients (*private and pauper*), which are addressed to the Lord Chancellor or any other Judge in Lunacy, to a Secretary of State, to the Commissioners or any one Commissioner, or to the person who signed the order or the petition, or to the Visiting Committee, visitors, or any one visitor of the asylum or house.

He may, at his discretion, forward to its address any other letter written by a *private* patient. Every letter not so forwarded must, within 24 hours, be posted to the Commissioners or (in the case of patients found lunatic by inquisition) to the Masters in Lunacy, unless meanwhile it is submitted to a Visiting Commissioner or Visitor in Lunacy.

The Commissioners and Masters in Lunacy may, at their discretion, forward, detain, or destroy any letter thus sent to them.

Every superintendent, &c., who fails to comply with these directions shall for each offence forfeit a sum not exceeding £20.

Notices to be posted up respecting Letters, &c.

(Clause 38.)

In every asylum, hospital, and licensed house there are to be posted in conspicuous places, "so that every patient may be able to see every such notice," printed notices showing

(a) The right of every *private* patient to have any letter forwarded to the Commissioners or Masters in Lunacy, if it is not sent to its address or within 24 hours submitted to a Visiting Commissioner or Visitor;

(b) The right of every *private* patient to request a personal and private interview with a Visiting Commissioner or Visitor at any visit.

The Visiting Commissioners or Visitors may select the places where these notices are to be posted.

Every superintendent, &c., failing to post such notices, or within 10 days to carry out such directions as may be given by the Visiting Commissioners or Visitors, shall for each offence forfeit a sum not exceeding £20.

Provision for any person to apply to have Patient examined.

(Clause 29.)

Any person may apply to have a patient (whether private or pauper) who is detained as a lunatic in any asylum, &c., or as a single patient, examined by two duly qualified medical practitioners. The Commissioners may grant an order for such examination to anyone, whether relative or friend of the patient or not, who shall satisfy them that it would be proper so to do, and who shall undertake to pay the expenses of the examination.

If, after two separate examinations with an interval of at least seven days, the two medical practitioners certify in writing that in their opinion the patient may safely be discharged, the Commissioners may order the patient to be discharged at the expiration of 10 days from the date of their order.

Escape of a Patient.

(Clause 62, 63, 64.)

Provision is made for the re-taking of any lunatic who, being lawfully detained in England, Scotland, or Ireland, shall escape from the country in which he is detained to either of the others.

In the case of such an escape from England to either Scotland or Ireland, notice of the escape must as soon as possible be given to the Commissioners in Lunacy; who may, by writing under their seal, authorise any person they think fit to apply to any J.P. having jurisdiction in the place where the lunatic was detained for a warrant, authorising such person to re-take and bring back the lunatic. Such a warrant shall, in Scotland and Ireland as well as in England, be sufficient evidence that the person to whom it refers was lawfully detained as a lunatic and had escaped; and shall be sufficient authority for any sheriff or sheriff substitute in Scotland, or for any J.P. in Ireland, having jurisdiction in the place where the escaped lunatic may be, to countersign the same. Any such countersigned warrant may be executed in Scotland or Ireland by re-taking and bringing back the lunatic.

In the case of a lunatic escaping from Scotland to England or Ireland, or from Ireland to England or Scotland, the method of procedure is the same, *mutatis mutandis*; notice of the escape being sent in the first place to the General Board of Commissioners in Lunacy for Scotland, or to the Inspectors of Lunatics in Ireland.

Abuse of Female Lunatic.

(Clause 65.)

This clause supplements 16 and 17 Vict., c. 96, s. 9, and 16 and 17 Vict., c. 97, s. 123, by providing that any such person as is mentioned in the sections referred to, who shall outrage, or attempt to outrage, or in any way behave indecently towards any female patient detained as a lunatic in any asylum,

criminal asylum, hospital, licensed house, or workhouse, or as a single patient, shall be deemed to be guilty of abusing or ill-treating such lunatic within the meaning of those sections respectively. Consent or alleged consent of the lunatic is no defence in case of indictment or prosecution.

Orders for Reception Expire at the end of Three Years unless Continued.

(Clause 21.)

Any order for the reception of a patient (private or pauper) into an asylum, &c., or as a single patient, dated after or within two years before the commencement of this Act, shall expire at the end of three years from its date, unless continued.

Any order dated more than two years before the commencement of this Act shall expire at the end of one year after the commencement of this Act, unless continued.

An order for reception shall remain in force for one year after the date at which it would otherwise have expired, if, not less than seven days before that date, there is sent to the Commissioners a special report of the medical officer of the asylum or the medical attendant of the hospital or licensed house or of the single patient as to the mental and bodily condition of the patient, with a certificate (see Form 11 in the Schedule) under his hand certifying that the patient is still of unsound mind, and a proper person to be detained under care and treatment.

This special report is to be made by the medical officer of an asylum to the visitors; and by the medical attendant of a hospital, or licensed house, or single patient, to the committee of visitors, the proprietor of the licensed house, or the person having charge of the single patient respectively. The person or persons to whom the report is made shall transmit it to the Commissioners, and shall give to the Commissioners any further information they may require.

If in the Commissioners' opinion the special report is unsatisfactory, or does not justify the accompanying certificate—

(a) In the case of a private person in a hospital or licensed house, or as a single patient, such patient is, as soon as convenient, to be visited by one or more Commissioners; and if it is the opinion of the visiting Commissioners that the patient ought to be discharged, the Commissioners may order his discharge.

(b) In the case of a private or pauper patient in an asylum, the Commissioners shall send a copy of the report, with such other information as they possess, to the Clerk to the Committee of Visitors of the asylum; and the Committee or any three of them are to investigate the case, and may discharge the patient, or give such directions as they think proper.

As the order, if continued, is only continued for one year, application for its continuance must be repeated every year, not less than seven days before the order would otherwise have expired.

An order for the transfer of a patient shall not be deemed to be an order for reception within this section, but after transfer the patient shall be deemed to be detained under the original order for reception, which (unless continued) shall expire as above provided.

The special reports under this section may include and refer to more than one patient; their form is to be directed by the Commissioners.

The Commissioners may, by order under their seal, direct that the orders for reception of patients in any asylum, &c., shall not expire till the last day of the quarter during which the orders would otherwise have expired.

Any superintendent, &c., who detains a patient after having knowledge that the order for his reception has expired, shall be guilty of a misdemeanor.

Removal for Health or on Trial, and Transfer.

(Clause 23.)

The written consent of *one* Commissioner, countersigned by the Secretary of the Commissioners, shall suffice for the exercise of the powers of removal for health or on trial, or of transfer, conferred by 8 and 9 Vict., c. 100, s. 86, 16 and 17 Vict., c. 96, ss. 20, 22, and 25 and 26 Vict., c. 111, s. 38.

When a private patient is removed from a hospital or licensed house to any specified place for the benefit of his health, or is allowed to be absent on trial, the superintendent or proprietor shall (unless the Commissioners have consented to the removal or absence) give notice to the Commissioners within three days, stating the place to which the patient has been removed, and the period and conditions for and upon which the removal or absence has been allowed.

Any superintendent or proprietor failing to send such notice shall for each day or part of a day during which default continues forfeit any sum not exceeding £10.

Provisions concerning Discharge and Removal.

(Clauses 22, 27, 36.)

The powers of ordering the discharge of a patient from a hospital or licensed house given to the Commissioners by 8 and 9 Vict., c. 100, ss. 76, 77, may be exercised after *one* visit to the patient by two Commissioners, instead of two visits as required by those sections; but no such order shall be made later than two days after the day of the visit.

When the Commissioners have made any order of discharge they shall forthwith serve it upon the superintendent or proprietor of the asylum, &c., where the patient is detained, or upon the person having charge of the single patient, and shall give notice of such order —

(a) In the case of a private patient, to the person who signed or obtained the order for reception, or who made the last payment on the patient's account;

(b) In the case of a pauper, to the guardians by whom the expense of maintaining the lunatic was paid.

Any person who, having been served with an order of discharge, detains a patient after the date of discharge appointed thereby, shall be guilty of a misdemeanor.

The notice required by 16 and 17 Vict., c. 96, s. 19 to be sent on the recovery of a patient shall state that, unless the patient is removed within seven days from the date of the notice, he will be discharged. If he is not so removed, he is to be "forthwith" discharged without further order.

C. The remaining sections include, in addition to provisions concerning asylums, lunatic hospitals, and licensed houses, various miscellaneous clauses dealing with persons found lunatic by inquisition, lunatics in private families, the maintenance of pauper lunatics at home, &c.

Persons found Lunatic by Inquisition.

(Clauses 9, 39.)

Any person found lunatic by inquisition may, if no committee of the person has been appointed, be received into an asylum, &c., or as a single patient, on the authority of an order under the hand of a Master in Lunacy.

If, upon inquisition, it is found that an alleged lunatic is capable of managing himself and is not dangerous to himself or others, but is incapable of managing his affairs, power is given to the Judge in Lunacy to dispense with the appointment of a committee of the person, and to appoint a committee of the estate only.

Property of a Lunatic.

(Clause 40.)

The property of a lunatic detained under order and certificates, or of any person who is proved to the satisfaction of the Judge in Lunacy to be incapacitated through mental infirmity arising from disease or age, may be dealt with by the Judge in Lunacy as if the person had been found lunatic by inquisition. The Judge may make an order appointing any person approved by him to exercise all the powers of a committee of the estate, or such special powers as may be mentioned in the order. Any person so appointed is subject to the jurisdiction of the Judge in Lunacy, just as if he were the committee of the estate of a lunatic so found by inquisition.

Lunatics in Private Families and Charitable Establishments.

(Clause 32.)

The Commissioners are empowered to require full information, including a report or periodical reports of the mental and bodily condition, concerning any person who is without an order and certificates detained or treated as a lunatic or alleged lunatic by any person receiving no payment for the charge, or in any charitable or religious establishment.

Any such patient may at any time be visited by one or more of the Commissioners, who may exercise in such case all the powers (except that of discharge) given to them as to persons confined in any asylum, &c., or as single patients.

The Commissioners may report on the case to the Lord Chancellor, who may thereupon make an order for the discharge of the patient, or for his removal to an asylum, &c., or to such other custody as he may think fit. In case of his removal to an asylum, provision is made whereby the lunatic's property may be made applicable to his maintenance as a pauper.

All reports and information sent to the Commissioners under this section shall be open to inspection only by the Commissioners, the Lord Chancellor, and such persons as the Lord Chancellor directs.

Maintenance for Pauper Lunatic taken charge of by Relations.

(Clause 31.)

Any relative or friend of a pauper confined in an asylum may apply to the committee of visitors for the said pauper to be delivered over to him; and if satisfied that he will be properly cared for, any two of the visitors may order the pauper to be delivered over accordingly. The person to whom he is delivered shall receive from the guardians of the union or the treasurer of the county or borough to which the lunatic is chargeable such allowance as they may think fit, not exceeding what it would have cost to keep him in the asylum. Every such lunatic shall be visited once every three months by a medical officer of the asylum, or (if more than three miles from the asylum) by a duly qualified medical practitioner to be approved and remunerated by the committee of visitors; and within three days after each visit the result thereof shall be reported to the committee of visitors of the asylum. At any time any two of the visitors may make an order for the lunatic to be brought back to the asylum.

Provisions as to Books, &c.

(Clause 35.)

The Commissioners may give directions as to the form of the medical case-book, the particulars to be entered therein, and the frequency of such entries.

The Commissioners may require any superintendent or proprietor to transmit to them, within a given time, a correct copy of any entry or entries in the case-book, and also a full report of the mental and bodily condition of any patient detained in the asylum, &c.

Any superintendent, &c., who fails to comply with such requisition shall for each day or part of a day during which default continues forfeit any sum not exceeding £10.

The entry as to the form of the patient's disorder (required by 8 and 9 Vict., c. 100, s. 51, to be made in the Book of Admissions within seven days after the patient's reception) shall be made within fourteen days after his reception.

Provisions concerning Asylums.

(Clauses 42; 53 to 58 inclusive; and 61.)

Lunatics not paupers may be received into any asylum provided under 16 and 17 Vict., c. 97, and the amending Acts, or under this Act, on such terms as to payment and accommodation as the committee of visitors may think fit. It is no longer required that a lunatic not a pauper admitted into an asylum shall have the same accommodation in all respects as the pauper lunatics.

The amount by which the charge for private patients exceeds the ordinary weekly charges for pauper patients, or so much thereof as may not be otherwise properly expended, may be carried to the asylum building and repair fund.

The committee of visitors of any asylum may, with the consent of the justices at the quarter sessions, and with the approval in writing of a Secretary of State, alter or enlarge the asylum as they may think fit for the purpose of providing accommodation for private patients. All plans and estimates for such alterations and additions are to be submitted to the Commissioners, who shall report thereon in writing to a Secretary of State; the Secretary of State may direct such alterations in the plans, &c., as he thinks fit.

The justices of any county or borough may, either alone or in union with the justices of any other county or borough, or counties or boroughs, make provision for the reception of private and pauper patients together or in separate asylums; they may provide separate asylums for idiots or patients suffering from any particular class of mental disorder.

If by a report of the Commissioners it appears to a Secretary of State that the justices of any county or borough have made no provision, or insufficient provision, for the accommodation of private or pauper patients; in any case in which the Secretary of State shall think it proper that provision or better provision for private patients shall be made, he shall make an order directing the justices within a given time to make (to the satisfaction of the Commissioners) such provision as may be required.

If this order is disobeyed it may be enforced by mandamus; or the Secretary of State may appoint some person to carry the order into effect. Any person so appointed may exercise all the powers conferred on justices of counties and boroughs by 16 and 17 Vict., c. 97, and the amending Acts.

Provision is also made for the borrowing, on the security of the local rate, of such sums as may be necessary for the carrying into effect of any such order; and also for the recovery from the justices of the amount expended in carrying the order into effect.

After the passing of this Act no contract between justices of a borough and the committee of visitors of an asylum for the reception of the pauper lunatics of the borough into the asylum shall be determined without the consent of a Secretary of State.

Provisions concerning Lunatic Hospitals.

(Clauses 43 to 52 inclusive.)

When application is made, after the passing of this Act, for the registration of a lunatic hospital, the managing committee or superintendent shall send to the Commissioners—

(a) A statement of the nature and constitution of the hospital, the mode of election, and the names and addresses of the members of the governing body;

(b) A plan of all houses, land, &c., to be used for the accommodation of lunatics (scale not less than $\frac{1}{8}$ of an inch to a foot); with a description of the situation of the hospital, and the dimensions of, and reference by figure or letter to, every room therein;

(c) A statement of the quantity of land not built on, appropriated to the exclusive use, exercise, and recreation of the patients;

(d) A statement of the number of patients of each sex to be received, and of the means by which the sexes are to be kept apart;

(e) A statement of the class of patients to be received, and the proposed scale of charges.

On receipt of these documents the Commissioners may depute one or more of their own body, or anyone else they may think fit, to inspect the hospital and report to them thereon.

If the Commissioners think that the hospital ought not to be registered, they are to make a written report to a Secretary of State, giving their reasons. The final decision rests with the Secretary of State.

If the Commissioners are of opinion, or a Secretary of State decides, that the hospital ought to be registered, the Commissioners shall issue a *provisional* certificate of registration, which shall be valid for six months from date of issue, unless previously superseded by a *complete* certificate of registration.

Within three months from the date of the provisional certificate, the managing committee of the hospital shall frame regulations, and submit them to a Secretary of State for approval. If the regulations are approved the Commissioners shall issue a *complete* certificate of registration.

Lunatics may be received in the hospital from the date of a provisional certificate; but if no complete certificate is granted, no lunatic may be received or detained after the end of six months from the date of the provisional certificate.

No lunatic shall be received in any hospital unless it has been registered before or (provisionally or completely) after the passing of this Act.

Any superintendent receiving or detaining a lunatic in a hospital contrary to the provisions of this Act shall be guilty of a misdemeanor.

Within three months from the commencement of this Act, the superintendent of every hospital registered before the passing of this Act (except Bethlem Hospital) shall send to the Commissioners the same documents as are required upon an application to register under this Act.

In default of doing this, he shall for each week of default forfeit a sum not exceeding £20.

No additions to, or alterations of, any registered hospital shall be made until full plans and descriptions have been submitted to the Commissioners, and have received their approval.

No building on the hospital property may be used in any way for the reception or the care and treatment of lunatics, unless such building is shown on the plans sent to the Commissioners.

If the superintendent of a registered hospital knowingly permits the infringement of this he shall be deemed guilty of a misdemeanor.

The accounts of every registered hospital shall be audited once a year by a chartered accountant, and shall be printed. The Commissioners may prescribe the form in which the accounts are to be kept.

The committee of any hospital may, out of profits, grant to any officer or servant who is incapacitated, or who has served the hospital for not less than 15 years, and is not less than 50 years old, a superannuation allowance, not exceeding two-thirds of the salary of the person superannuated.

On or before December 31st in each year the superintendent of every hospital shall send to the Commissioners—

(a) A list of the names, addresses, and descriptions of the members of the governing body, and the principal medical and other officers of the hospital.

(b) A copy of the last printed accounts. Any superintendent failing to comply shall for every week during which default continues forfeit any sum not exceeding £10.

The following persons are disqualified from being members of the governing body of a registered hospital:

(a) Any medical or other officer of the hospital;

(b) Any one interested in or sharing in the profits of any work done for the governing body or managing committee of the hospital; this disqualification does not extend to a person who is a member of a company which has done any such work.

The Commissioners may require the superintendent or any other officer of a hospital to give them any information they think fit as to the way in which the hospital regulations are carried out. If they are of opinion that the regulations are not properly carried out, they may call the superintendent's attention to such fact, and require amendment. If within six months the superintendent has failed to attend to and carry out the Commissioners' requirements, they may, with the consent in writing of a Secretary of State, order the hospital to be closed, so far as the reception and detention of lunatics is concerned. If any lunatics are detained in the hospital after the date appointed by the order for closing the hospital, the superintendent shall be guilty of a misdemeanor.

After the passing of this Act no agreement shall be made between the justices of any county or borough and the subscribers to a hospital for uniting to provide and maintain an asylum, or for the reception of pauper patients into the hospital.

Provisions concerning Licensed Houses.

(Clause 41.)

After the expiration of five years from the commencement of this Act no pauper patient shall be received in any licensed house, neither shall any licence for the reception or detention of paupers in a licensed house be granted or renewed.

After the commencement of this Act no new licence for a house for the reception of lunatics shall be granted by justices without the previous consent of the Commissioners (in writing, under their common seal).

When a licence has been transferred by the justices of a county or borough under 8 & 9 Vict., c. 100, s. 39, a copy of the instrument of transfer shall be within 3 days after date sent to the Commissioners by the clerk of the peace. If he fail to send it, he shall for each day during which default continue forfeit forty shillings.

In the case of a licence granted to two or more persons, if before the licence expires any of such persons die leaving the other or others surviving; the licence shall remain in force if the survivor or one of the survivors has undertaken, or within 10 days after the death does undertake (in writing to the Commissioners or the justices who granted the licence) to reside in the house.

Visitors of licensed houses are to be appointed by the justices of every county or borough, whether there is a licensed house within the county or borough or not. In any county or borough in which no visitors of licensed houses have been appointed heretofore, the justices shall appoint such visitors at the next quarter sessions after the commencement of this Act.

Provision is made for the remuneration of the medical visitor for services rendered under this Act.

Prosecution; Defaults and Misdemeanors.

(Clauses 66, 67, 68.)

From and after the commencement of this Act, the power given by 8 & 9 Vict. c. 100, s. 56, to a Secretary of State, to direct the Attorney-General to prosecute on the part of the Crown in certain cases, shall be extended to all misdemeanors committed by any persons under this or any other Lunacy Act.

Any person making default in sending to the Commissioners any report, &c., when required under this or any other Lunacy Act, shall for each day or part of a day during which default continues forfeit any sum not exceeding £10.

Any person obstructing a Commissioner in the exercise of his powers shall for each offence forfeit any sum not exceeding £50, and shall also be guilty of a misdemeanor.

Any person guilty of any act or omission which under 8 & 9 Vict., c. 100, s. 90, is punishable as a misdemeanor, shall also for every such act or omission be liable to a penalty not exceeding £50.

If any person is proceeded against, under this or any other Act relating to lunacy, for omitting to send any document required to be sent by such person, the burden of proof that the document was sent within the time required, shall lie upon such person; but if he proves by the testimony of one witness upon oath that the document in question was properly addressed and posted in due time, or (if so required) left at the office of the Commissioners or of the clerk of the peace, such proof shall be a bar to all further proceeding in respect of such omission.

Definitions.

(Clause 71.)

"The Judge in Lunacy" means the Lord Chancellor or any Judge of the Supreme Court of Judicature entrusted for the time being with the care and commitment of the custody of the persons and estates of idiots, lunatics, and persons of unsound mind.

"Relative" means a lineal ancestor or lineal descendant, or a lineal descendant of an ancestor not more remote than great-grandfather or great-grand-mother.

THE SCHEDULE.

FORM 1.—*Petition for an Order for reception of a Private Patient.*

In the matter of *A.B.*, a person alleged to be of unsound mind.
To the judge of the county court of [or To stipendiary magistrate
for , or To a justice of the peace for .]
The petition of *C.D.* of [1] in the county of
1. I am over the age of twenty-one years.
2. I desire to obtain an order for the reception of *A.B.*, a lunatic [2] in the asylum of
situate at [3]
3. I last saw the said *A.B.* at on the [4] day of
4. I am the brother [5] of the said *A.B.* [or if the petitioner is not connected with or related
to the patient state as follows:]
I am not connected with or related to the said *A.B.* The reasons why this petition is not
presented by a relation or connection are as follows: [State them.]
The circumstances in which this petition is presented by me are as follows: [State them.]
5. I am not related to or connected with either of the persons signing the certificates
which accompany this petition as (where the petitioner is a man) husband, father, father-in-
law, son, son-in-law, brother, brother-in-law, partner or assistant, (or where the petitioner is
a woman) wife, mother, mother-in-law, daughter, daughter-in-law, sister, sister-in-law,
partner or assistant.
6. I undertake to visit the said *A.B.* personally or by some one specially appointed by me
at least once in every six months while under care and treatment under the order to be made
on this petition.
7. A statement of particulars relating to the said *A.B.* accompanies this petition.
The petitioner therefore prays that an order may be made in accordance with the fore-
going statement.

(Signed)

Dated

full Christian and surname.

[1] Full postal address and profession or occupation. [2] Or an idiot or person of unsound mind. [3] Insert a full description of the name and locality of the asylum, hospital, or licensed house, or the full name, address, and description of the person who is to take charge of the patient as a single patient. [4] Some day within 14 days before the date of the presentation of the petition. [5] Or whatever the connection or relationship may be.

FORM 2.—*Statement of Particulars.*

STATEMENT of particulars referred to in the annexed petition [or in the above or annexed order].

The following is a statement of particulars relating to the said *A.B.* [1] —

Name of patient, with Christian name at length.
Sex and age.

†Married, single, or widowed.

†Rank, profession, or previous occupation (if any).

†Religious persuasion, as far as known.

Residence at or immediately previous to the date hereof.

†Whether first attack.

Age (if known) on first attack.

When and where previously under care and treatment as a lunatic, idiot, or person of unsound mind.

†Duration of existing attack.

Supposed cause.

Whether subject to epilepsy.

Whether suicidal.

Whether dangerous to others.

Whether any near relative has been afflicted with insanity.

Whether found lunatic by inquisition, and date of inquisition.

Names Christian names and full postal addresses of one or more relations of the patient.

Name of the relative to whom notice of death to be sent, and full postal address if not already given.

When the petitioner or person signing an urgency order is not the person who signs the statement, add the following particulars concerning the person who signs the statement.

{	Name.
	Occupation (if any).
	Degree of relationship (if any) or other circumstances of connection with the patient.
	(Signed)

[1] If any particulars are not known, the fact is to be so stated. [Where the patient is in the petition or order described as an idiot omit the particulars marked †].

FORM 3.—Order by a Judge of County Courts, Stipendiary Magistrate, or Justice for reception of private patient.

I, the undersigned *E.F.*, being the Judge of the County Court of _____, [or a Stipendiary Magistrate, or a Justice for _____] upon the petition of *C.D.*, of [1] _____ in the matter of *A.B.*, a lunatic, [2] accompanied by the medical certificates of *G.H.* and *I.J.* hereto annexed, and upon the undertaking of the said *C.D.* to visit the said *A.B.* personally or by some one specially appointed by the said *C.D.* once at least in every six months while under care and treatment under this order, hereby authorise you to receive the said *A.B.* as a patient into your asylum [3]

Dated _____

(Signed)

E.F.

The Judge of the County Court of _____

[or a Stipendiary Magistrate, or a Justice for _____] asylum for the county of _____ or to _____ as the case may be.]

[1] Address and description. [2] Or an idiot or person of unsound mind. [3] Or hospital or house or as a single patient.

FORM 4.—Form of urgency Order for the reception of a private patient.

I, the undersigned, being a person over twenty-one years of age, hereby authorise you to receive as a patient into your house [1] *A.B.*, a lunatic [2], whom I last saw at _____ on the [3] _____ day of _____ 18 _____. I am not related to or connected with the person signing the certificate which accompanies this order in any of the ways mentioned in the margin [4]. Subjoined [or annexed] hereto [5] is a statement of particulars relating to the said *A.B.*

(Signed)

Name

Rank or profession (if any)

Full postal address

Degree of relationship (by blood or marriage) to patient

[If not a relative, the person signing to state as briefly as possible: 1. Why the order is not signed by a relative. 2. His connexion with or interest (if any) in the patient, or the circumstances inducing him or her to sign.]

Dated this _____ day of _____ 18 ____.

To _____, proprietor or superintendent of _____ house [6] [or hospital or asylum].

[1] Or hospital, or asylum, or as a single patient. [2] Or an idiot, or a person of unsound mind. [3] Some day within seven days before the date of the order. [4] Husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law, partner, or assistant. [5] See Form 2. [6] Describing house or hospital or asylum by situation and name.

FORM 5.—Order by County Court Judge, Stipendiary Magistrate, or Justice for enlargement of time under Urgency Order.

I, the undersigned, *E.F.*, being the judge of the county court of _____ [or a stipendiary magistrate, or a justice, for _____], having had presented to me the petition of *C.D.* of _____, in the matter of *A.B.*, a lunatic [or a person of unsound mind], who is now detained at [where state the place of detention, whether an asylum, hospital, licensed house, or as a private patient] under an urgency order which, unless enlarged by me, would expire on the day of _____, do hereby, by this present writing under my hand, order that the time

during which the said urgency order shall remain in force shall be, and the same is hereby, enlarged until the day of

(Signed) E.F.
The judge of the county court of [or stipendiary magistrate for or a justice for].

FORM 6.—*Certificate of Medical Practitioner.*

I, the undersigned A.B., do hereby certify as follows:

1. I am a person registered under the Medical Act, 1857, and I am in the actual practice of the medical profession.

2. On the [1] day of 18 , at [2] in the [county [3] of [separately from any other practitioner] [4], I personally examined C.D. of [5] in the county [6] of [7], and came to the conclusion that he is a [lunatic, an idiot, or a person of unsound mind] and a proper person to be taken charge of and detained under care and treatment.

3. I formed this conclusion on the following grounds, viz.:—

(a) Facts indicating insanity observed by myself at the time of examination.

(b) Facts communicated by others [8].

4. I am not acquainted with the contents of any other medical certificate relating to the mental condition of the said C.D. made within the last seven days.

[If an urgency certificate is required it must be added here. See Form 7.]

5. I give this certificate having first read the clause of the Act of Parliament printed below.

Dated (Signed) A.B., of [9].

[Clause of Act making wilful mis-statement a misdemeanor.]

[1] A day not more than seven clear days before the date of the presentation of the petition or three clear days before reception under the urgency order, as the case may be. [2] Insert the name of the street or place, with number or name of house, or, should there be no number, then insert Christian and surname of occupier. [3] City or borough, as the case may be. [4] Omit this where only one certificate is required. [5] Insert residence of patient. [6] City or borough, as the case may be. [7] Insert profession or occupation, if any. * * * If the same or other facts were observed previous to the time of the examination, the certifier is at liberty to subjoin them in a separate paragraph. [8] The names and Christian names (if known) of informants to be given, together with their names and addresses. [9] Insert full postal address.

FORM 7.—*Certificate of Urgency.*

I certify that it is expedient for the welfare of the said C.D. [or for the public safety, as the case may be] that the said C.D. should be forthwith placed under care and treatment.

My reasons for this conclusion are as follows:

FORM 8.—*Certificate as to pauper Lunatic in a Workhouse.*

I, the undersigned Medical Officer of Workhouse of the Union hereby certify that I have carefully examined into the state of health and mental condition of A.B., a pauper in the said workhouse, and that he is in my opinion of unsound mind, and a proper person to be kept in the workhouse, and that the accommodation in the workhouse is sufficient for his proper care and treatment.

The grounds for my opinion that the said A.B. is of unsound mind are as follows:

Dated

(Signed)

Medical Officer of the Workhouse.

FORM 9.—*Order for detention of Lunatic in Workhouse.*

I, the undersigned A.B., a justice of the peace for [] being satisfied that C.D., a pauper in the workhouse of the is a lunatic [or idiot or person of unsound mind] and a proper person to be taken charge of and detained under care and treatment in the workhouse, and being satisfied that the accommodation in the workhouse is sufficient for his proper care and treatment, hereby authorise you to take charge of and detain the said C.D. as a patient in your workhouse. Subjoined is a statement respecting the said C.D.

(Signed)

A.B.,

A justice of the peace for

Dated

To the Master of the

Workhouse

of the

Statement.

Name of patient and Christian name at length. Sex and age. Married, single, or widowed. Condition of life and previous occupation (if any). Religious persuasion as far as known. Previous place of abode. Whether first attack. Age (if known) on first attack. When and where previously under care and treatment. Duration of existing attack. Supposed cause. Whether subject to epilepsy. Whether suicidal. Whether dangerous to others. Whether any near relative has been afflicted with insanity. Union to which lunatic is chargeable. Name and Christian name and address of nearest known relative of the patient and degree of relationship if known. I certify that to the best of my knowledge the above particulars are correct.

[To be signed by the relieving officer.]

FORM 10.—*Order for reception of a Pauper Lunatic.*

I, *C.D.*, having called to my assistance *E.F.*, of _____, a duly qualified medical practitioner, and being satisfied that *A.B.* [*describing him*] is a pauper [in receipt of relief, or in such circumstances as to require relief for his proper care and maintenance], and that the said *A.B.* is a lunatic [or an idiot, or a person of unsound mind] and a proper person to be taken charge of and detained under care and treatment, hereby direct you to receive the said *A.B.* as a patient into your asylum [or hospital, or house]. Subjoined is a statement respecting the said *A.B.*

(Signed) *C.D.*,
A justice of the peace for the city or borough of _____
Dated the _____ day of _____ one thousand eight hundred and _____
To the superintendent of the asylum for the county [or borough] of _____ [or the lunatic
hospital of _____; or proprietor of the licensed house of _____; describing
the asylum, hospital, or house].

Note.—When the order directs the lunatic to be received into any asylum, other than an asylum of the county or borough in which the parish or place from which the lunatic is sent is situate, or into a registered hospital or licensed house, it shall state, that the justice making the order is satisfied that there is no asylum of such county or borough, or that the asylum or asylums thereof is or are full; or (as the case may be) the special circumstances, by reason whereof the lunatic cannot conveniently be taken to an asylum for such first-mentioned county or borough.

Statement.

[If any particulars in this statement are not known, the fact to be so stated.]

Name of patient, and Christian name at length. Sex and age. Married, single, or widowed. Condition of life, and previous occupation, if any. The religious persuasion, as far as known. Previous place of abode. Whether first attack. Age (if known) on first attack. When and where previously under care and treatment. Duration of existing attack. Supposed cause. Whether subject to epilepsy. Whether suicidal. Whether dangerous to others. Parish or union to which lunatic is chargeable. Name and place of abode of the nearest known relative of the patient, and degree of relationship, if known.

(Signed) *G.H.*
[To be signed by the relieving officer or overseer].

FORM 11.—*Certificate that patient continues of unsound mind.*

I, _____, certify that *A.B.*, the patient to whom the annexed report relates, is still of unsound mind, and a proper person to be detained under care and treatment.

(Signed) _____
Medical officer of the _____ asylum, or
medical attendant of the _____
hospital or _____ house situate at _____
_____, or medical practitioner
visiting the said *A.B.*

Dated _____

FORM 12.—*Sanction by the Commissioners in Lunacy for the Admission of a Boarder.*

We hereby sanction the admission of _____ as a boarder into _____ for the term of _____
from the _____ day of _____ in accordance with the provisions of the statute and
in terms of _____ application.

(Signed) _____
Given at the office of the Commissioners in Lunacy, London, this _____ day of _____ 18____

FORM 13.—*Notice of Admission.*

I hereby give you notice that *A.B.* was admitted into this house as a private boarder on the _____ day of _____

(Signed) _____
Superintendent or proprietor of the
house situate at _____
Dated this _____
To the Commissioners in Lunacy.

FORM 14.—*Notice of Discharge of Boarder.*

I hereby give you notice that *A.B.*, a boarder received on the _____ day of _____ into this house, was discharged therefrom on the _____ day of _____ 18____

(Signed) _____
Superintendent or proprietor of the
house situate at _____
Dated _____
To the Commissioners in Lunacy.

FORM 15.—*Certificate for Admission to Institution for Idiots and Imbeciles.*

I, the undersigned *A.B.*, a person registered under the Medical Act, 1857, and in the actual practice of the medical profession, certify that I have carefully examined *C.D.*, an infant or [of full age], now residing at _____, and that I am of opinion that the said *C.D.* is an idiot [or has been imbecile from birth, or for _____ years past or from an early age], but is capable of receiving benefit from care, instruction and training.

Dated _____

(Signed) _____
(full postal address).

Appointments.

JACKSON, ARTHUR, M.B., B.A.Oxon., M.R.C.S., appointed Assistant Medical Officer, Surrey County Lunatic Asylum.

MORTIMER, J. D., M.R.C.S., L.S.A.Lond., appointed Assistant Medical Officer to the Portsmouth Borough Asylum.

PADDISON, EDMUND H., M.D.Lond., M.R.C.S., appointed Assistant Medical Officer to the City of London Lunatic Asylum, Stone, *vice* Mercier, resigned.

WOOD, J. OTTERSON, F.R.C.P.Ed., F.R.C.S.Ed., M.R.C.S., appointed Resident Medical Superintendent of Sussex House and Brandenburg House Asylums, *vice* Dr. L. S. Forbes Winslow, resigned.

FINEGAN, ARTHUR, L.K.Q.C.P., L.R.C.S.I., Assistant Medical Officer, Northumberland County Asylum, Morpeth, appointed Medical Superintendent of the Mayo District Asylum, Castlebar.

"The Blot upon the Brain."—Under this title, Dr. Ireland is about to issue a work which consists of "Studies in History and Psychology." The subject of Hallucinations will form an important feature of the book. Other subjects are discussed, as the Insanity of the Caesars, Lefthandedness, &c. The work, which will be one of much interest to medical psychologists, will be published by Messrs. Bell and Bradfute, Edinburgh.

ERRATA.

JOURNAL, APRIL, 1885.

p. 95, line 24—for "by" read "for."

p. 106, line 5—for "1480" read "480."

p. 107, line 24—for "300" read "140."

p. 107, line 25—for "building" read "ward."

THE JOURNAL OF MENTAL SCIENCE.

[Published by Authority of the Medico-Psychological Association]

No. 135. NEW SERIES,
No. 99.

OCTOBER, 1885.

VOL. XXXI.

PART 1.—ORIGINAL ARTICLES.

Presidential Address, delivered at the Annual Meeting of the Medico-Psychological Association, held at Queen's College, Cork, August 4, 1885. By J. A. EAMES, M.D., F.R.C.S.I.

GENTLEMEN,—Allow me in the first place, on my own part and that of my *confrères*, to thank you for the very great compliment you have paid the members of the Medico-Psychological Association who are in the Irish asylum service, through me, by doing me the honour to select me as your President for the ensuing year. For myself personally, I regret your choice has not fallen on one better able to fill such a high position; and I feel I have no claim whatever beyond your kindness in wishing to extend your friendship to your fellow-workers in this country. In their name, therefore, I bid you a hearty welcome to the fair city of the South, and trust that your visit may not only be attended with present pleasure, but that you may carry with you pleasing reminiscences of your stay amongst us.

You will no doubt visit as many of our asylums as you conveniently can while in Ireland, and although you will not find them in interior arrangements, &c., on a par with those in the sister isle, I entertain the hope you will find that we are animated with the same desire to improve in every way we can the condition of the insane—that most afflicted, at the same time most interesting, class of sufferers who are committed to our care.

It is difficult to do more on an occasion like the present than to take a cursory glance at the subjects I propose bringing under your notice in connection with the treatment of insanity, from a sanitary point of view, and asylum management in general.

In the first place, the question may be asked: Is insanity on the increase? I am aware this is a vexed question. Some

eminent authorities believe it is; others that it is not. My experience is that, from whatever cause, it is decidedly on the increase.

The number of patients in this asylum in the year 1873, the first year of my appointment, was 687; in the year 1883 the number was 926, or nearly 35 per cent. more in 10 years. No doubt the accumulation of those patients admitted from year to year who have neither died nor been discharged would account for some increase, but not, in my opinion, for so large a number; and although during that period this asylum was enlarged so as to accommodate 250 additional patients, we must now build accommodation for at least 250 more.

The next question is, to what is this increase to be attributed? I think there can be no doubt it is to the yearly increasing higher pressure, so to speak, at which the lower classes especially live, and the greater struggle consequently for existence. Intemperance is also more general amongst this class, producing in its wake all its consequent evils, domestic troubles, &c., and also affording greater inducements for committing crime.

The same state of affairs exists in the other parts of this country. All the district asylums have been, or are about to be, enlarged to meet the increasing demand for admissions.

A good deal of controversy has taken place with regard to the suitability of workhouses for the treatment of harmless and incurable lunatics who are not considered fit cases for the more expensive treatment of an asylum, and thus relieve the latter to some extent.

In my opinion, those cases should be treated in a separate and less expensive establishment than an asylum, but under the supervision and control of the lunatic department, thus keeping all lunatics distinct from any other board or body.

In this way they would be under the care of paid attendants and special medical supervision, and by erecting one or more large buildings of this class in a province, all the incurable cases could be transferred thereto from the different district asylums of that province, after having been pronounced by the medical officers of those institutions that they were incurable and harmless, and not fit to be detained there any longer. If the Government extended the rate-in-aid grant to these patients the cost on the ratepayers would not be so much as it is at present in the workhouses, while

they would receive those special advantages so much required in their afflicted state.

With regard to the asylums in this country, we cannot pretend, as I stated before, to compare with our richer brethren in the other portions of this kingdom as regards ornamentation and internal decoration; nor do I think it is necessary, taking into consideration the comparative position of patients in both countries. Here they are chiefly of the agricultural class; in England and Scotland, on the contrary, artisans in the receipt of good wages, and accustomed to city life and corresponding home comforts, form a large quota of the asylum population.

To such patients these adjuncts are desirable and necessary; not so with the patients of a rural population, for whom clean airy dormitories, day-rooms, and galleries, with inexpensive adjuncts, such as birds, window plants, &c., with good bedding, clothing, and plain wholesome food, are quite sufficient to meet all their requirements.

To these, amusements of a healthy character for those not fitted for work are added; but most essential of all, I think, are the evening dances which are held here regularly four nights weekly. All the patients look forward with pleasure when the day is over to these two hours of amusement in the recreation hall.

I was always of opinion that if this was beneficial to patients one night weekly, it was four times more so on four nights. On the evenings there is no dancing it is impossible to prevent the attendants allowing patients to retire to bed soon after supper; there is nothing for either to do, and time becomes irksome to both. When the patients go to bed at this early hour they cannot sleep, and thus their night's rest is spoiled. On this account I have always insisted upon two hours being spent in the recreation hall on at least four nights in the week; 500 patients generally attend.

I now wish to draw your attention to a speciality in this asylum with regard to the sanitary treatment of the patients, which is, I think, of the greatest importance, viz., the Turkish bath. This is the only asylum that I am aware of in which it is used solely for the purpose of ablution, and the first, I believe, in which a Turkish bath was used for any purpose.

It is some years now since my predecessor, the late Dr. Power, a gentleman of marked ability, who spent the greater part of a long life and devoted all his energies to the

amelioration of the insane, was authorized to erect a bath, with the assistance of the late Dr. Barter, of Blarney, capable of accommodating about 120 patients daily. This was found to be, many years afterwards, too small for the increasing number of patients; and about two years ago a double bath was ordered to be built, at my suggestion, by the governors of this asylum, for males and females, sufficiently large to give 250 baths daily, which has lately been completed. When you remember how necessary it is to produce and keep up a healthy condition of the skin of the insane, the advantage of the Turkish bath cannot be over-estimated. The process of cleansing is quite different from the ordinary bath when given even under the most favourable circumstances, because the skin, as it were, is cleansed from within outwards, the pores being thoroughly opened by the process of perspiration, and the surface effectually purified by soap and the shower afterwards. To say nothing of the medical effects produced upon the melancholic and demented, whose circulation, as is well known, is so sluggish and imperfect, the bracing and tonic influence of the cold shower at the end of the bath is most beneficial. It should not be lost sight of that in the Turkish bath each patient has clean water used by no other person; not so, I think, in other systems of bathing generally. I need scarcely say that in cases where the Turkish bath is not permitted here those patients get the ordinary warm bath instead; and in no case is a patient sent to the Turkish bath without permission having been first obtained from a medical officer.

I have only spoken of the advantages of the Turkish bath as a cleansing agent in all cases, and a curative one in many.

I would now desire to bring a few facts before you as to its superiority to the ordinary bath, with regard to the time required, the labour to the attendants necessary to bathe patients, and the enormous quantity of water required to perform the operation efficiently by the latter method.

I may mention, I was medical superintendent of an asylum, where the only system of baths was the ordinary reclining one, for nearly eight years before my appointment to Cork. The efficient bathing of patients was a matter that always engaged my serious attention, and I endeavoured, by paying frequent visits on these occasions, to find out how far it was possible to give a patient a proper bath in a moderate space of time, because that is the main

point when you come to deal with a population of some hundreds.

The result of my inspections was anything but satisfactory. I found that, calculating the time it took to let sufficient water flow into the bath to cleanse the patient thoroughly, and to let the water escape, that it could not be done under a quarter of an hour at least. This means four patients in the hour, or 32 in the day of eight hours for each bath. I should rather say three instead of four would be nearer the correct number.

In the next place, would there be sufficient storage for hot water for baths on this calculation? I know there was not, from my experience, and the result, in my opinion, of this system of bathing is that it is quite impossible to prevent attendants from putting three or four patients into the same water, to economise water, time, and labour.

This, I need not say, was a most objectionable practice, and must be my excuse for trespassing so long upon your time with this subject, and the hope that the consideration of the question may induce others to adopt the Turkish bath in the same way as it is used here.

Another sanitary arrangement I wish briefly to mention is the use of turpentine and bees'-wax, instead of soap and water, for washing, or rather cleansing, the floors throughout the asylum.

In our damp climate, and especially in the winter months, we found it took a very long time to dry the floors after being washed, and the feeling of damp, together with the smell and the humid atmosphere, made it most uncomfortable and unwholesome for the patients, who were obliged to spend all their time inside in wet weather. Since this new method has been adopted the floors have become quite dry and hard on the surface, and consequently much easier to be kept clean. In addition to the above advantages, it is rather less expensive than soap. I would, therefore, recommend it to your favourable notice.

The question of appointing assistant medical officers in this country has engaged a good deal of attention. Several assistants have been appointed, and I have no doubt that before the expiration of another decade every asylum in Ireland will have an assistant medical officer. This is a step in the right direction, as there cannot be a second opinion about the desirability of such an appointment. In having a medical officer always present the

records of cases can be kept more efficiently than when there is only one resident medical officer, in addition to the advantage of training men for the position of medical superintendents.

Another very serious question in asylum management is that of attendants. I think a great deal might be done to ameliorate their condition and make their life more contented. Their duties are very arduous and depressing, entailing long hours of confinement, not to speak of responsibility and even danger. In this country their pay is much less than elsewhere, and I should like to see it raised to the same standard, the duties being the same. In addition to this, I think it would tend to make them more contented with their position if, when they married, they were provided with cottages, built either on the estate or in the vicinity, by the governors, they paying a rent sufficient to cover the cost of building, &c. I think it would also be very desirable, in the interests of the asylum service generally, if there could be some sort of register established by which no man could get employment in any asylum from another without the medical superintendent's knowledge. I have known great inconvenience arise from want of this. It would be the means of letting men know they could not get an appointment without the medical superintendent under whom they served being written to in the first instance, and a good character obtained from him, as well as a satisfactory reason given for the attendant leaving his situation. I am aware this has been suggested before, but do not know if it has been carried out.

Many attendants take a turn of a few months' duration at several asylums. Nothing can be more detrimental than this practice; they infuse the same erratic ideas into the minds of their fellow-attendants in each institution they visit, and make them unsettled also. Another great disadvantage our attendants suffer from is the long service they are compelled to perform before they can retire on full pension.

At present this subject is being agitated, and I hope successfully. I certainly think 25 years ought to entitle an attendant to a full pension, and not 40 years, as is the case at present, which means really nothing, no one, I should say, being able to comply with such terms; whereas, were it changed, attendants would enter upon the life with the view of remaining until they had served the time

prescribed. Should attendants become incapacitated while in the service they should receive a pension proportional to the time served.

I need not point to the beneficial results which would accrue from having such a staff of attendants, the increased number of cures likely to be effected, and the improved condition of those placed under their care. We would have experienced and reliable attendants, who know their patients, and whom the patients value and become attached to. Contrast this with new hands, who know nothing of the responsibility of their charge, who have no interest or pleasure in their work, and if irritated by a troublesome or violent patient, are very likely to return a blow for a blow, or otherwise maltreat them, unless closely watched, and when spoken to give notice to leave, not placing any value on their situations.

While we are behind you in many matters, we must take credit for being in advance of you in one important particular, namely, having a course of instruction in mental diseases made compulsory in the curriculum of the Royal University of Ireland, and be obliged to pass an examination in the same before obtaining the degree of M.D. To Dr. O'Sullivan, President of the Queen's College, Cork, the honour is due of being the first to move and carry out successfully this desirable change. Some ten years ago, recognizing the importance of medical students receiving instruction in mental diseases, he obtained the sanction of the governing body of the District Asylum for the County and City of Cork, and the authority of the Government, that a course of lectures be delivered annually in that institution by the resident medical superintendent.

As regards the delivery of such a course of lectures in Ireland, so far back as the year 1845 an Act of Parliament was passed (8 and 9 Victoria, cap. 107, sec. 22), which enacts: "That it shall and may be lawful for the Lord Lieutenant of Ireland, or other Chief Governor or Governors of Ireland for the time being, by and with the advice of Her Majesty's Privy Council in Ireland, to make and found such rules and regulations for the holding of lectures by the medical attendant or attendants of the said central asylum, or said provincial or district asylum, or any of them, as to the said Lord Lieutenant or other Chief Governor or Governors may seem fit."

Nothing seems to have been done in the way of giving practical effect to this Act until the Lunatic Asylums

(Ireland) Commission, which was held in 1856. The Commissioners then made the following remarks in their report presented to Parliament:—

“We now desire to draw attention to the great benefits which the district asylums of Ireland might be capable of conferring, if made available as educational establishments for the purpose of extending a knowledge of the nature and treatment of insanity. At present these institutions may be considered as almost effecting nothing towards so important an object. We feel confident that if the lunatic asylums of Ireland were made places of instruction, medical science would be increased and humanity benefited. We cannot doubt that if proper exertions were made, students of medicine or graduates who had just completed their course would seek for appointments as residents in asylums, as the knowledge thus acquired, and the certificates they would obtain of such residence, would be highly-esteemed recommendations in many positions in which they might afterwards be placed. We would recommend that, in the first instance, the experiment of appointments should be made in the asylums of Dublin (Swift’s, St. Patrick’s, and the Richmond), of Cork, and of Belfast, in which towns there are large medical schools. Such resident pupils might be appointed by the board of governors, on the recommendation of the resident physician, and should be subject to his direction. We would propose that the time of residence should be six months, or perhaps it might be advisable to extend it to a longer period, and that on the expiration of such residence a certificate should be given by the resident physician or the Board of Governors of the manner in which the duties of the appointment had been fulfilled.”

The latter suggestion has been carried out, the Government having authorised the appointment of assistant physicians and resident pupils in district lunatic asylums in Ireland.

The first recommendation of the Commissioner, strange to say, has never been carried into effect in this country, until within the last two years, by the Royal University in Ireland.

This is attributable to the fact that no steps in the direction indicated have been taken by the governing bodies of the various colleges and medical schools. In the year 1875 a petition was presented to the Medical Examining Board in England praying that three months’ clinical

instruction in a lunatic asylum might be substituted for a like time of study in a general hospital.

The grounds upon which this petition was presented, showing the necessity for its prayer being granted, are of such importance that I cannot do better than quote them.

1st. "That the courses of lectures on mental diseases hitherto delivered were not imperative on students of medicine as a part of their curriculum or professional study."

2nd. "That although students have a sufficiently large number of subjects which they have to master during their period of study, the entire absence of any provision for the clinical study of such an important branch of medicine as insanity and its kindred diseases, cannot but be prejudicial to the interests of a large majority of students in their future career."

3rd. "That insanity is not, like other diseases, to be met with in the wards of a general hospital, and that consequently students have no opportunity for observing it without attending at a lunatic asylum."

4th. "That the University of London has the following regulation and note thereon: 'Attendance during three months in the wards of a lunatic asylum, recognised by the University, with clinical instruction, may be substituted for a like period of attendance on medical hospital practice.' The Senate regard it as highly desirable that candidates of the degree of M.B. should practically acquaint themselves with the different forms of insanity by attendance at a lunatic asylum."

5th. "That if the regulations laid down by the University of London were adopted by the University Examining Boards, a great boon would be conferred on many students, who might then, without sacrifice of time, avail themselves of the opportunities of studying a class of diseases with which at present they have little or no practical acquaintance, but which are, of all others, liable to entail on medical practitioners heavy losses both of prestige and fortune."

This petition bore the signatures of all the most eminent psychological physicians both in England and Scotland, the result of which was the following resolution by the Royal College of Physicians: "That students who wish to qualify for the examinations for the membership or the license of the College, may substitute, if they so desire, a three months' course of clinical instruction in the wards of a lunatic

asylum for the same period of attendance in the medical wards of a general hospital."

The Queen's University, as I have already stated, adopted this course, and on the establishment of the Royal University the latter enacted that a course of lectures on mental diseases, with clinical instruction in a recognised lunatic asylum, must be included in the curriculum of a student intending to graduate in that University, and to be examined in those and allied diseases when presenting himself for his examination for his surgical and medical degree.

Within the last ten days the following circular has been issued by the Royal University of Ireland, showing that that University is fully alive to the necessity of encouraging proficiency in the knowledge of mental diseases :—

"Royal University of Ireland,
"Earlsfort Terrace, Dublin,
"13th July, 1885."

"Sir,—Under a scheme lately settled by the Court of Chancery concerning the application of the education bequests of the late Dr. Henry Hutchinson Stewart, the Senate of this University will offer in the autumn of this year one scholarship of the annual value of £50, tenable for three years, for proficiency in the knowledge of mental diseases.

"The competition will be limited to graduates in medicine of this University of not more than two years' standing. The examination, which will commence on 19th October next, and will occupy at least three days, will include the treatment of mental diseases, diseases of the brain and spinal cord, diseases of the nervous system, and examination with the microscope of pathological specimens and preparations illustrative of such diseases.

"There will be a practical examination of patients labouring under those diseases, and candidates will be required to submit to the examiner written reports on the cases thus examined.

"Each medical scholar elected for proficiency in the subject of the treatment of mental diseases, must, as the condition of holding such scholarship, proceed (within six months from the date of his election to such scholarship) to some recognised institution for the treatment of mental diseases, to be approved by the Senate, and there continue as either an outdoor or resident pupil, for a period of not less than six months.

"Forms of application for admission to the examination, which will be supplied on request, must be returned to us, duly filled up, on or before the 19th September next.

"Yours faithfully,

"J. C. MEREDITH, } Secretaries."
"D. B. DUNNE, }

Why the study of mental diseases has not been made compulsory by all the licensing bodies years ago I cannot understand, when the importance of the duties of the medical practitioner in connection with the certifying of lunatics is considered, as well as the facts, long since conceded, that insanity is as much a disease as gout or rheumatism, and that it is no doubt increasing (certainly not decreasing), and, therefore, it is a matter of serious moment that every means should be taken to reduce such a social calamity to a minimum, it being well known the curability of the disease depends upon its being treated early.

The first thing, therefore, towards the attainment of this end should be the recognition of the malady in its earliest stages by the practising physician, so that cases as they arise may be sent to an asylum or placed under proper treatment, and thus afford the patient the best chance of recovery.

The treatment of insanity by the family doctor is looked upon as something outside his regular practice. He has not been accustomed to see such cases, and when brought before him, he refers them to a specialist as something mysterious, that ordinary treatment cannot touch. The approach of an attack is either unobserved, or treated simply as low spirits or the result of indigestion.

Possibly he has never seen a case of mental disease. He is totally unskilled in the symptoms which to a trained mind would have given forewarning of an impending attack.

This has been a serious blot in our medical teaching. The insane action or idea as surely springs from a morbid derangement of the brain as a bilious attack from a morbid condition of the liver. There is no mystery about it; it is a mental manifestation arising from a physical cause, and should form as necessary a branch of study as lung or heart disease.

The separation of disease of one organ, and that the highest, the brain, from general medical study, cannot but be a fruitful cause of incipient insanity being allowed to degenerate into confirmed lunacy.

The practising physician should, therefore, be able to foresee the approach of an attack; but if he has never

studied psychological medicine, and consequently has no knowledge of the progress of the disease from day to day, the chance of averting the evil has been lost, and when the patient has become a confirmed lunatic, he is taken to a specialist if his friends can afford it; if not, he is sent to an asylum, in too many instances to remain there until death relieves him from his sufferings. In addition to the foregoing reasons, namely, the necessity for checking the progress of insanity as far as possible in a social point of view, as well as the benefit conferred thereby on the individuals themselves, there is another important view to take as regards the safety of the medical practitioner himself, and the injury he may inflict upon an individual when signing a certificate, why it is absolutely necessary he should be obliged to be conversant with this malady. It is impossible, if he holds any public appointment, he can escape signing such certificate when called upon to do so. This means to deprive a man of his liberty, to consign him to an asylum, and to have him pronounced a lunatic, which will stick to him for the rest of his life, and if he have any children, especially daughters, will certainly injure their prospects more or less.

I look upon signing a document which can do this as by far the most important which a medical man can be called upon to deal with, and in many instances fraught with serious consequences.

Why it has been allowed to go on unnoticed by the Legislature I cannot imagine. It has no doubt been proposed that no certificates should be signed except by physicians conversant with insanity—specialists—but I fear that would be an expensive process, providing so many experts for the vast number of lunatics certified.

The practitioner, in addition to signing the certificate, may be called upon to give evidence in support of it in a court of law—the soundness or unsoundness of mind of his patient, his responsibility or the reverse, possibly involving the peril of life or death.

Having regard, then, to the efficient fulfilment of all these important and responsible duties, how can it be expected that the medical man can do so without a knowledge of those diseases which form the base of his enquiries? Is it by inspiration, or is it considered that they are not of sufficient importance to deserve more than a passing notice?

When the universities and other licensing bodies demand a knowledge of mental diseases from all students in medicine, and not until then, will this unsatisfactory state of

things be remedied, and insanity meet with an important check in its progress.

I now conclude these observations, and will be glad to receive your opinion upon the various topics I have referred to. It is certain that, in this large meeting of this branch of our profession, some new ideas may be elicited which will be the means of improving the condition of those entrusted to our care.

I thank you, gentlemen, for the kind and patient hearing you have given me, and again express my grateful acknowledgments for the honour you have conferred, through me, upon the Irish Lunatic Asylum Service.

A Contribution to the Study of Diseases of the Circulatory System in the Insane. (The Essay to which the £10 10s. prize of the Association was awarded). By T. DUNCAN GREENLEES, M.B. Edin., Assistant Medical Officer Cumberland and Westmorland Asylum, Garlands, Carlisle.

It has long been recognised that a sympathetic connection exists between the body and the mind; irritability of temper from a sluggish action of the liver, and the hopeful view phthisical patients frequently take of their ultimate recovery (the "*spes phthisica*" of some authors), are familiar examples of the influence of abnormal conditions of the body upon the mind.

The ancients were in the habit of treating all cases of insanity solely as bodily diseases, and Hippocrates taught that mental diseases were all due to the circulation of black bile in the blood, while others of the same school considered that insanity was due to a determination of blood to the head—a view still maintained by many who consider the more acute types of insanity as essentially due to cerebral hyperæmia.

Dr. Ellis* classifies, among the causes of insanity, those acting upon the brain (a) physically or morally, and (b) those whose action is purely sympathetic. He states that diseases of the various viscera are very frequently causes of insanity, the brain in these cases acting in sympathy with the diseased organ. Although he mentions pathological conditions of most of the viscera among those physical causes of insanity, he omits diseases of the circulatory organs in proof of his argument.

* "Treatise on Insanity," 1838, page 82.

Several observers, both before and after Ellis, have directed attention to the connection between heart disease and insanity; many of their observations were so limited in extent that their deductions are variable, and their conclusions can only be accepted *pro tanto*.

Of the more trustworthy of these observers may be mentioned Esquirol, who found heart disease to exist in $\frac{1}{15}$ of his melancholic patients; Bayle in $\frac{1}{6}$; Calmeil and Thore in nearly $\frac{1}{3}$; Webster in $\frac{1}{8}$; and, more recently, Sutherland in $\frac{1}{6}$ of all cases of insanity examined. In 602 post-mortem examinations made in the Insane Department of Vienna Hospital the heart was found to be diseased in 75 cases, but in some of these the disease was very slight. Defour* found lesions of the heart in 74 per cent. of his autopsies, and Dr. Sutherland† in his Croonian Lectures states that he found heart disease to exist in 34 cases out of 42 post-mortem examinations. In an exhaustive paper by Dr. Burman,‡ to which I shall have occasion to refer frequently, he states that the heart was diseased in 169 cases out of 500 post-mortem examinations.

Before entering more precisely into a consideration of the relationship between heart disease and insanity, I commence my inquiry by tabulating the causes of death in 218 consecutive autopsies of insane individuals in this asylum:—

TABLE I.—Showing the Cause of Death in 218 Consecutive Autopsies.

Cause of Death.	M.	F.	Total.	Percentage.
Diseases of Nervous System	47	24	71	32·56
Exhaustion : Senile or from Mental Disease	16	20	36	16·51
Diseases of Lungs (excluding Phthisis)... ..	11	11	22	10·08
Tubercular Disease of Lungs	18	13	31	14·12
Diseases of Heart	21	11	32	14·67
Diseases of Digestive System	9	7	16	7·33
Diseases of Genito-Urinary System	2	1	3	1·33
Diseases of Locomotory System	4	3	7	3·21
Totals	128	90	218	

* "Journal Mental Science," Vol. xxiv., p. 136.

† "Journal Mental Science," July, 1861.

‡ "West Riding Asylum Reports," Vol. iii., p. 235.

The above table shows that, in point of frequency, heart disease occupies an important position as a cause of death among the insane, occurring third in the list; diseases of the cerebro-spinal system being first with nearly one-third of the total; and exhaustion from either senile decay or mental disease second, forming $16\frac{1}{2}$ per cent. of the total. It is interesting to note the relative frequency of phthisis as a cause of death in asylums. Dr. Clouston* found phthisis to exist with such frequency and to give such distinctive characters to the type of insanity as to justify the name of "phthisical insanity" being applied to this disease. According to this table phthisis, as a cause of death, does not occur with the same frequency as heart disease, although no doubt in many of the cases tubercular deposits were found in one or both lungs. The difference, however, in point of frequency between phthisis pulmonalis and heart disease as causes of death, in my statistics, is very slight.

An inquiry into the condition of the heart and blood-vessels among the insane, and the relationship between pathological changes in the circulatory system and insanity, naturally subdivides itself into two parts—a statistical and a pathological division.

I. Statistical Division.

In order to elucidate this subject it is my intention to consider the following:—

(1.) The condition of the heart as found among the living insane.

(2.) The condition of the general circulation and the pulse in the insane.

(3.) Heart disease as a primary cause of death among the insane.

(4.) Pathological changes observed in the heart and blood-vessels of those dying insane, including those changes not necessarily contributing to the fatal issue.

(5.) The percentage of deaths from heart disease or arterial changes among the general public.

(6.) Conclusions and deductions from the above.

(1.) *The condition of the heart as found among the living insane.*

In the following table the state of the heart is described in patients on their admission, as it is probable that, at this

* "Journal Mental Science," April, 1863.

time, the patients' mental state is at its worst, and most likely, if ever, to have some deleterious influence on the heart's action.

TABLE II. Showing the Condition of the Heart on Admission.

Mental Condition.	Total No. of Cases Examined.			Cardiac Disease Present.			Cardiac Functional Derangements.			Percentage of Heart Disease.	Percentage of Functional Derangements.
	M.	F.	T.	M.	F.	T.	M.	F.	T.		
Mania	183	225	408	19	31	50	70	102	172	12·25	42·15
Melancholia	48	74	122	5	7	12	23	39	62	9·83	50·80
General Paralysis... ..	31	8	39	5	1	6	14	3	17	15·38	43·58
Epileptic Insanity	15	12	27	1	1	2	5	5	10	7·40	37·03
Dementia and Imbecility	40	27	67	5	10	15	19	8	27	22·38	40·29
Other Cases... ..	6	3	9	0	1	1	4	2	6	11·11	66·66
Totals and Averages...	323	349	672	35	51	86	135	159	294	12·94	43·75

This table represents a total of 672 individuals, 323 males and 349 females; 86, or almost 13 per cent. of the total, were found to suffer from recognisable heart disease, and 294, or nearly 44 per cent., had functional disorders of that organ—a condition in which the functions of the heart were not normal, although actual evidence of organic disease could not be detected on examination. I have classified under this heading such conditions as the heart-sounds being weak or almost inaudible; the rhythm irregular; re-duplication or accentuation of one or other of the sounds; the heart's action being loud and tumultuous, associated with a pulse rapid or abnormally slow, irregular or intermitting, weak or compressible. It is difficult to assign the effect of the mental condition of the patient upon the functions of the heart, but a reference to the table shows that as functional derangements occur with greater frequency among recent and acute cases of insanity than among the more chronic and stationary types, it is reasonable to assume that excitement has some effect in producing deranged action of the heart. It would appear that heart disease occurs with greater frequency among chronic types of insanity, such as dementia and imbecility, where, according to the above table, it is present in

one out of every four cases. It is a more frequent accompaniment of mania than of melancholia, although the proportion of cases of cardiac functional disorder is greater in the latter condition. The state of the heart and circulation in general paralysis is an interesting study; it is difficult to explain the frequency of heart disease in this condition. If we accept the theory, propounded first, so far as I am aware, by Dr. Milner Fothergill,* that general paralysis is a disease essentially originating in a hyperæmic and distended condition of the perivascular spaces in the brain resulting in increased arterial tension, we might expect to find, in long-standing cases, hypertrophy of the left side of the heart, and probably in time, evidences of valvular lesions, especially of the aorta. Dr. Fothergill, however, states that he did not discover sufficient evidence to show that the heart was diseased; in fact, he argues that general paralytics enjoy a comparative immunity from heart disease.

In epilepsy heart disease does not appear to be common. The ages of the patients may probably assist in explaining this fact, most of the epileptics being between the ages of 20 and 30 on admission, some under 20, and few above 40 years of age, and, according to the Registrar General, heart disease, as a cause of death, is rare in persons under 20 years of age. Of the 27 epileptics examined, the only two who presented evidence of organic cardiac disease were both upwards of 60 years of age, one male and one female. Both patients had a well-defined presystolic mitral murmur.

It will be advisable at this stage of inquiry to consider more fully the condition of the heart in those patients who presented the clinical symptoms of cardiac disease or arterial atheroma on admission.

Of the cases which I am able to classify, the following is a list:—

(1.) *Mitral Systolic Murmurs*.—This murmur generally replaces the first sound of the heart, and is booming in character; it occurred in 32 cases, and in point of relative frequency in the following types of mental disease:—Mania, melancholia, dementia, general paralysis, and epilepsy.

(2.) *Presystolic Murmurs*.—A murmur occurring immediately before the first sound of the heart, and harsh, grating, or rubbing in character. This condition was found in 15

* "The Heart Sounds in General Paralysis." (West Riding Asylum Reports, Vol. iii., p. 113.)

cases, and, according to its relative frequency, in mania, dementia, melancholia, and epilepsy.

(3.) *Double Aortic Murmurs*.—A double “see-saw” murmur, replacing both the systole and the diastole of the heart, a condition, according to authorities, indicating a very serious condition of the organ. 11 cases are recorded as having this murmur, and of the cardiac lesions found in general paralytics, this is the chief form of disease from which they suffer.

(4.) *Hypertrophy of the Heart*.—It is, as a rule, difficult in insane patients to make a satisfactory examination of the extent of the cardiac area of dulness; hence this will explain why only six cases are recorded presenting this condition to any marked extent. This condition occurred in two cases of mania, three of dementia, and one melancholic. Although I have been unable to find any increase in the area of cardiac dulness among general paralytics during life, examination of the heart after death generally reveals some amount of hypertrophy.

(5.) *Accentuation or Reduplication* of one or other of the heart’s sounds or other abnormal conditions of the heart’s action, was found in 43 per cent. of the total. The peculiar condition of the heart’s action and sounds in some of these cases, was such as to convince me of some organic change, although of what nature I was unable to decide.

An accentuated or reduplicated condition of one or other of the heart’s sounds occurs very commonly in general paralysis. In nine cases of general paralysis which I recently examined, only one had normal sounds; in five, the second sound was accentuated, terminating suddenly, and ending in a “click;” in two the first sound was impure, and the second accentuated, and in another case the first sound was markedly accentuated. An accentuation of the second sound of the heart Dr. Fothergill explains as due to the aortic valves being closed by a larger volume of blood above them than is usually the case.

(6.) *Atheroma, or Thickening of the Arteries*, was found in eight cases, occurring in point of frequency in the following mental conditions:—Mania, general paralysis, dementia, and melancholia; the average age of the eight cases was $69\frac{1}{2}$ years.

Forms of Insanity in which heart disease occurs in the living insane.

As the preceding remarks refer to the condition of the circulatory organs of patients on their admission, it is important

to note that the mental condition of the inmates of asylums frequently undergoes changes.

Cases of mania or melancholia sometimes merge into secondary dementia, or even in time develop the symptoms of general paralysis. Thus, although heart disease is found to occur most frequently in cases exhibiting the symptoms of mania on admission, from a systematic examination of the present residents in the asylum I find that heart disease occurs more frequently among cases exhibiting the mental phenomena of secondary dementia and melancholia than among other types of insanity. With regard to the mental characteristics of such of the inmates as exhibit the physical signs of heart disease, they are generally morose, suspicious, or passionate, and cases of profound melancholia are liable to outbursts of temper. The connection between the delusions of the insane and the presence of organic visceral disease is an interesting study, and the irregular action of the heart in many cases gives rise to strange delusions, such as the workings of an unseen agency, as electricity, within them. It has been noticed that occasionally sane patients who suffer from heart disease exhibit the same mental characteristics; they are not infrequently found to be quick-tempered, easily excited, and sometimes extremely passionate. Probably in both cases the altered condition of the temper and mental faculties is due either to the local irritation of a diseased heart, or to a diminution of the proper nourishment to the brain, or else an actual poisoning of the nerve-centres from failure of the eliminating apparatus to remove the effete matters in the circulating blood.

(2.) *The Condition of the General Circulation of the Insane.*

In every asylum population cases are to be found in which the circulation is impaired, the pulse slow and feeble, and the extremities cold, or even livid and swollen. These cases are generally to be found among two classes of patients—(1) recent cases of acute melancholia, and (2) old standing cases of dementia or other chronic forms of insanity. With respect to the first class, it would appear that the impaired action of the circulation, from some of the many causes that give rise to starvation of the tissues, is the cause of the diseased mental condition. In the second class, the slow process of the evolution of impulses from the nerve-centres to the peripheral organs acting in some way as an inhibitor of the heart, is probably the true explanation. In a population of 530 insane (280 males and 250 females), I have found

one or other of the above conditions present in 59 cases (28 males and 31 females), the temperature at the time of examination being above 60° in the open air. These cases may be classified as follows:—Chronic mania, 7 males and 7 females; melancholia, 8 males and 5 females; general paralysis, 1 female; epileptic insanity, 4 males and 4 females; dementia, 8 males and 10 females; imbecility, 1 male and 2 females. Two female examples of *folie circulaire* also presented this condition of extreme coldness of the extremities.

An impaired circulation thus occurs with greater frequency among demented, and is not necessarily associated with heart disease, for in very few of these cases did I find evidence of organic cardiac disease. A course of stimulating treatment in the first class of cases is often successful in causing a disappearance of the physical symptoms of impaired cardiac action, followed by an improvement in the mental condition of the patient.

TABLE III.—Showing the Average Pulse-Rate in the Insane at Three Different times.

Mental Condition.	No. of Cases Examined.			Pulse Rate on Admission.	Average Pulse Rate. Morning.			Average Pulse Rate. Evening.			Averages.	
	M.	F.	Total.		M.	F.	Total.	M.	F.	Total.	M.	F.
Acute Mania ...	24	30	54	98·78	107·17	85·12	96·14	86·33	79·18	82·75	97·42	87·69
Mania ...	66	66	132	82·00	85·33	80·14	82·74	78·21	81·82	80·02	81·84	81·32
Melancholia ...	33	33	66	96·30	87·56	82·20	84·88	75·39	81·85	78·62	86·41	86·81
General Paralysis ...	23	8	31	78·16	82·26	80·25	81·25	81·39	80·75	81·07	80·60	79·72
Epilepsy ...	17	11	28	83·50	87·17	75·00	81·09	80·24	74·18	77·21	81·89	77·56
Dementia ...	15	17	32	84·30	82·66	76·88	79·77	70·80	80·58	75·69	83·90	80·58
Imbecility ...	10	5	15	82·60	79·40	76·80	78·10	71·20	75·20	73·20	77·73	78·20
Totals and Averages ...	188	170	358	86·52	87·36	79·49	83·42	77·93	79·02	78·47	84·25	81·70
Healthy pulse...					82	87	84	74	80	77	78	83

The subject of the condition of the pulse as found among the insane has been so well worked at that there will be no

necessity of very extended observations in this place. The figures in the above table differ only slightly from those given by Dr. Clouston,* who found the average rate of the pulse in the insane to be—morning, 84; evening, 74. The pulse, according to my observations, is quicker in insane males than in sane males, and slower in insane females than in sane females; and my observations agree with Dr. Clouston, who states that, although the temperature of the evening is, as a rule, above that of the morning, the evening pulse is, with a few slight exceptions, below the pulse of the morning. As might be expected, acute mental excitement acting upon the heart increases its pulsations, hence we find that in both acute and sub-acute mania the pulse is rapid. On the other hand, the morning and evening pulse-rates in imbecility, and the average morning pulse-rate in dementia, are below the normal standard. In general paralysis the pulse-rate is only slightly above normal; it is, however, the character of the pulse in this disease that is of interest. Dr. Milner Fothergill† describes it as “the hard pulse of increased arterial tension, such as characterises chronic Bright’s disease,” and, according to Dr. Thompson,‡ the sphygmographic tracings of the pulse in this disease represent what is seen in spasm of the muscular coats of the arteries, “due to a heightened susceptibility on the part of the vaso-motor system to such influences as are likely to affect it.”

In epilepsy the pulse-rate is slightly above normal; and, with respect to its character, Dr. Thompson states that the tracings represent a lax condition of the vessels.

It will be seen from the above observations that the pulse-rate is higher in the insane than the sane, the exceptions to this rule being cases of dementia and imbecility, where, however, as was previously pointed out, the heart’s action is frequently slow and the circulation generally sluggish. The morning pulse-rate is, as a rule, higher than the evening pulse-rate in insanity—the average difference being about five beats per minute. This average difference is most in acute mania, and least in general paralysis. The pulse-rate is over all about two beats per minute more rapid in male insane patients than in female patients. It may be as well to state that Dr. Clouston found the female pulse-rate

* “Journ. Mental Science,” April, 1863.

† “West Riding Asylum Reports,” Vol. iii., p. 117.

‡ “Journ. Mental Science,” 1875, p. 582.

to be five beats more on an average per minute than the male pulse-rate. The greatest difference in the rate of the pulse in the different sexes was found in acute mania, and the least difference in general paralysis.

(3) *Heart Disease as a Primary Cause of Death among the Insane.*

TABLE IV.—Showing the Proportion of Deaths from Heart Disease and Cardiac Lesions during a period of five years in this Asylum.

Mental Condition.	No. of Cases Examined.			Heart Disease as the Cause of Death.			Pathological changes in Heart or Vessels.			Percentage of Cases of Heart Disease.	Percentage of Cases of Changes.
	M.	F.	T.	M.	F.	T.	M.	F.	T.		
Mania ...	50	53	103	7	10	17	36	40	76	16.60	73.78
Melancholia ...	20	13	33	3	2	5	12	9	21	15.15	63.90
General Paralysis ...	29	4	33	3	0	3	14	4	18	9.99	54.54
Epileptic Insanity ...	16	3	19	0	0	0	10	4	14	0.00	73.68
Dementia and Imbecility ...	19	12	31	4	1	5	14	8	22	16.13	70.96
Other Cases ...	2	1	3	0	0	0	2	0	2	0.00	66.66
Totals and Averages ...	136	86	222	17	13	30	88	65	153	13.51	68.72

This table is formed from accurate records of the post-mortem appearances observed of all deaths during a period of five years.

A reference to the table shows that during this period 222 autopsies were made, that the heart was diseased to such an extent as to constitute of itself the primary cause of death in 30 cases, being 1 in every 7.4 cases examined, and that in 153 cases, or 68.7 per cent. of the total, the heart and vessels were not healthy, being sufficiently diseased to constitute a secondary or more remote factor in the fatal issue. In the 33 examples of general paralysis, the paralysis was the primary cause of death: of these three were stated to be "heart deaths," while in 18 of the remainder, or fully one-half of the total cases, the heart or vessels presented changes more or less pathological.

A similar state of matters existed where, in other cases, the primary factor in the causation of death was a lesion of the nerve centres; the heart disease present in these cases being considered only the secondary cause of death.

It will be observed that, according to this table, the proportion of deaths from heart disease during five years closely corresponds with the proportion of insane who exhibited symptoms of heart disease on admission during the same five years as detailed in Table II.

Thus, on admission, heart disease occurs in the proportion of one in every 7·81 cases, and it is the assigned cause of death in one of every 7·40 deaths, a proportion considerably higher than that given by Dr. Burman, who found that heart disease was the cause of death in one out of every 13·45 deaths.

TABLE V.—Showing the Ages of Patients who were recognised to have Heart Disease on their Admission, and at Death.

Age.		Total No. of Cases Examined.		Heart Disease.	Heart Disease.
		On Admission.	At Death.	On Admission.	At Death.
Under 20	...	35	0	0	0
20 under 30	...	133	13	11	0
30 „ 40	...	160	40	6	4
40 „ 50	...	136	43	15	4
50 „ 60	...	93	40	21	8
60 „ 70	...	76	42	24	9
70 „ 80	...	27	37	8	5
80 upwards	...	7	7	1	0
Totals	...	672	222	86	30

It will be observed that, according to my statistics, heart disease occurs on admission with greater frequency in the female sex, but that, as a cause of death, it is more frequent in the male sex. Both on admission and at death, heart disease occurs with greater frequency between the ages of 60 and 70, being in the proportion of 1 in 3·12 of the

total admissions, and 1 in 3·66 of the total deaths at this age.

To supplement the information derived from deaths from heart disease at this asylum, I add another table giving the proportion of deaths from heart disease in other asylums. This table is made up from statistics contained in the annual reports of these asylums during the year 1881, and, in addition, I have summed up the total number of deaths due to heart disease in this asylum during the twenty years previous to the five years from which my previous statistics are taken.

The following statistics refer to 31 annual reports of English asylums, 10 reports of Irish asylums, 18 reports of Scotch asylums for the year 1881, and 20 annual reports of this asylum.

TABLE VI.—Showing the Relative Frequency of Heart Disease in various Asylums.

	Average No. Resident.			No. of Deaths.			No. of Deaths from Heart Disease.			Percentage of Heart Disease
	M.	F.	Totals.	M.	F.	Totals.	M.	F.	Totals.	
English (31)	8826	10087	18913	965	755	1720	52	50	102	5·90
Scotch (18) ...	3548·7	3973·5	7522·2	287	323	610	27	32	59	9·70
Irish (10) ...	3110	2915	6025	310	258	568	19	18	37	6·50
20 years here	3955	3376	7331	356	235	591	19	17	36	6·09
Totals and Averages ..	19,489·7	20,351·5	39,791·2	1918	1571	3498	117	117	234	7·05

The general object I had in compiling this table was to show the proportion of deaths from heart disease in a large insane population; it represents a total average of 39,791 individuals, with a mortality of 3498, a percentage of 8·79 calculated on the resident population. Of these deaths from all causes, 234 were due to heart disease, a percentage of 7·05 of the total deaths, and 51 per cent. of the total living population.

Analysing the table, it is interesting to note that in 20 years at this asylum the mortality from heart disease is as low as 6·09 per cent., whereas in the following five years it rises to 13·51 per cent.; it is difficult to explain this fact. In the infancy of this asylum a large majority of the deaths

were due to "nerve lesions," and the percentage of "heart deaths" was almost *nil*. I noticed that as the number of inmates increased the death-rate rose, and at the same time the proportion of cases of heart disease increased even out of all proportion to the mortality.

The following English asylums had upwards of 10 per cent. of deaths from heart disease, calculated on the total number of deaths in the year recorded:—Broadmoor (18.18 per cent.), Kent (13.79 per cent.), Cumberland and Westmorland (12.50 per cent.), Stafford (11.32 per cent.), West Riding (10.95 per cent.), and Salop and Montgomery (10.25 per cent.). In the remaining 25 asylums the percentage was below 10 during the year.

In connection with this subject it is interesting to compare the geographical distribution of insanity with the distribution of heart diseases in the country. Dr. Clouston* has published a table showing the distribution of insanity in the different counties. This table has been used in a slightly modified form by Dr. Burman in his paper already referred to. It is found that the above six counties are—with the exception of West Riding—contained in Dr. Burman's first group which represents the counties where the proportion of the insane to the sane population is above the general average, being, as he shows, in the proportion of 2.34 per thousand in the upper, or first, group, as compared with 2.14 per thousand in the lower group. With respect to the presence of West Riding in this upper group, Dr. Burman found a percentage of 7.43 from heart disease in a large number of consecutive deaths, while in the annual report to which I refer the death-rate from heart disease was 10.95 per cent.

From the above facts, and from similar conclusions arrived at by Dr. Burman, it is inferred that heart disease, as a cause of death among the insane, occurs with greater frequency in those localities where the proportion of the insane to the sane is greatest.

- (4.) *Pathological Changes observed in the Heart and Blood Vessels of those Dying Insane, including those changes not necessarily contributing to the fatal issue.*

The following table represents the pathological changes found in the heart and vessels in 222 consecutive post-mortem examinations, and the information contained in

* "Journal Mental Science," 1873.

it will be better understood if each column is considered separately.

TABLE VII.—Showing the Pathological Changes found in the Heart and Vessels of those Dying Insane in this Asylum during a period of Five Years.

Mental Condition.	Total Number Examined.			Average Weight of Heart in ounces.			Hyper- trophy of Heart.					Valvular Disease of Heart.		Disease of Arteries, Local or General.
	M.	F.	T.	M.	F.	Average.	Right.	Left.	Atrophy of Heart.	Muscular substance fatty, pale, or flabby.	Pericardial changes.	Aortic.	Mitral.	
Acute Mania ...	3	2	5	8.25	8.50	8.38	1	1	1	2	0	0	0	2
Mania ...	47	51	98	12.36	13.97	11.67	18	26	4	50	37	15	22	50
Melancholia ...	20	13	33	11.12	10.40	10.76	4	10	0	19	9	7	7	19
General Paraly- sis ...	29	4	33	17.56	9.11	10.83	4	9	1	16	8	3	10	23
Epileptic In- sanity ...	16	3	19	10.08	9.37	9.72	0	1	1	10	0	0	0	9
Dementia ...	17	10	27	11.90	8.12	10.01	3	8	2	15	7	5	4	17
Imbecility ...	4	3	7	17.25	5.50	11.37	1	3	0	3	1	1	3	3
Totals and Averages ...	136	86	222	11.93	8.86	10.40	31	58	9	115	62	31	46	123

(1.) *Weight of the Heart.*—It is evident that an increase in the size, and hence weight, of the heart is indicative of more or less hypertrophy, but it is important not to forget that an excess of fat deposited external to the organ may increase its weight although there may be no evidence of true hypertrophy. The healthy human adult heart weighs, according to Mæckel, about 10 ounces. Dr. Peacock† is more precise, for he states that the heart of a male adult weighs on an average 9oz. 8drs., and of a female adult 8oz. 13drs.; or it may be more roughly put, male heart = $9\frac{1}{2}$ oz.; female heart = $8\frac{1}{2}$ oz. Dr. Boyd‡ gives a higher average weight; in 2,614 autopsies (about 1.5th of which were on insane subjects) the male heart weighed on an

* "Monthly Journal of Medical Science" (Edin.), Vol. xix., p. 211.

† "Philosophical Transactions," 1861, p. 241,

average 11·83oz., and the female heart 9·86oz. Among the insane he found the average weights to be somewhat below these figures, viz., 11·14oz. and 8·67oz. respectively. Dr. Burman gives the average weight in 487 autopsies in West Riding Asylum as, males = 12·62oz., and females = 10·26oz., or nearly one ounce and half an ounce respectively higher than the weights given by Dr. Boyd.

In 222 autopsies, I found the average weight of the hearts of the insane to be 11·93oz. and 8·86oz. respectively, a proportion between that recorded by the above two observers.

A reference to the weight of the heart detailed in the above table shows that the lightest hearts were found among cases of acute mania, where the organ appears, as a rule, to be both light and atrophied. On the other hand, in ordinary mania, the weight is greater than in any other of the forms of mental disease.

The heaviest hearts in the series were found in general paralysis: three paralytics were recorded as having had organic cardiac disease; and the weights of these hearts were respectively 31½oz., 29oz., and 24oz., an average of 28·16oz. in the three.

In two cases of melancholia, the heart weighed 17oz. each; in two dementes, 15oz. and 14oz.; and in two imbeciles, both with pronounced organic disease, the hearts weighed respectively 21oz. and 19oz.

In epileptic insanity, the average weight of the heart is lower than in other types of mental disease, with the exception of acute mania; in 19 cases it weighed 10·08oz. and 9·37 oz. respectively.

If we consider the average weight of the healthy adult heart to be 11·93oz. in males, and 9·86oz. in females, the hearts of the male insane are a fraction above this figure, and those of the female insane considerably below that of the healthy female. If, however, we exclude from the calculation the five cases of acute mania, where a small or even atrophied heart appeared to be common, then the average weights of the heart among the insane will be respectively 13·38oz. and 9·84oz., a considerable increase over the weight of the heart of the sane male, but still the heart of the female insane is lighter by ·02oz. than that of the healthy female.

(2.) *Hypertrophy of the Heart.*—A hypertrophied condition of the heart has already been pointed out by several observers to exist in general paralysis, and other diseases associated

with disorganisation of the brain; it would seem that in these cases of brain atrophy and thickened vessels, the cerebral circulation is much interfered with, and that this in time results in cardiac hypertrophy. Long continued muscular exercise causes an increase in the growth of muscular fibre, and the cardiac muscle is not exempt from hypertrophic change. Not only does muscular strain exercise this influence over the heart's muscle, but cases are on record of mental excitement or emotional states, if long continued, resulting in dilation of the cavities or hypertrophy of the walls of the heart. Tissot* observes that emotional states or even chagrin may produce dilatation of the heart and aorta, which, if not immediately fatal, must in time result in more or less hypertrophy; and, reasoning from this, long-continued mental excitement must necessarily cause a dilated, and latterly a hypertrophied, heart.

Dr. Pietro† states that he found hypertrophy of the heart common among the insane; in 48 examinations, 43 cases were hypertrophied. He believes the condition to commence in the right ventricle, and to be due to changes in the sympathetic. A reference to Table VII. shows that of 222 cases examined, the heart was hypertrophied in 89; in 31, the hypertrophy affected chiefly the right side, while in 58 the left side was involved. In the larger number the hypertrophy was most marked in the left ventricle, and in many of the cases of right-sided hypertrophy, the left side took part in the change as well. Hypertrophy occurred in 44.9 per cent. of the cases of mania examined; 42.4 per cent. in melancholia; 40.7 per cent. in dementia; and 39.3 per cent. in general paralysis.

This percentage in general paralysis exceeds that of Dr. Boyd,‡ who found cardiac hypertrophy in 22 per cent. of his cases of general paralysis.

(3.) *Atrophy of the Heart*.—This condition is not a common one in the insane; it occurred in only nine cases, 4.05 per cent. of the total number examined. In no case was the weight of the heart as low as 5oz. The paucity of examples of cardiac atrophy among asylum patients is curious, for, according to the various text books,§ atrophy of the heart is generally consequent upon wasting diseases, and a large

* Quoted by Dr. D. H. Tuke, "Journ. Ment. Science, Vol. xvii., p. 164.

† Quoted "London Medical Record," March, 1885.

‡ "Journal Mental Science," Vol. xvii., p. 20.

§ "Tanner's Practice of Medicine," Vol. ii., p. 28.

proportion of the deaths in asylum practice are those of long-continued and exhausting diseases. The smallest heart which I have found occurred in a dement, the organ weighing only $5\frac{1}{2}$ oz. In the cases of atrophy recorded, the heart weighed from 6 oz. to 7 oz. as a rule.

(4.) *The Muscular Substance* of the heart is frequently found pale, flabby, soft or fatty, in patients dying insane. Some of the cases recorded in this column had an excess of fat accumulated external to the organ, others presented a pale yellow or greasy condition of the muscular substance, but in the majority the muscle was pale, flabby, and softened. Although few cases were examined microscopically, yet from the peculiar condition of the muscular wall, probably many of these hearts had a true infiltration of fat between the muscular fibres. Dr. Howden* found four examples of true fatty degeneration of the heart, all in females, in 235 autopsies. In the 222 cases which I have recorded, 26 are reported to have had pale yellow or greasy hearts, most of these cases occurring either in old age or associated with slow and exhausting diseases. Two died from pernicious anæmia, a few from pneumonia, but it was chiefly in connection with phthisis pulmonalis that the heart, together with the other organs of the body, was found to present a fatty appearance.

(5.) *Affections of the Pericardium*.—Inflammation of the pericardium, although rare as a recent condition in the insane, is met with not unfrequently after death. An excess of the normal fluid in the pericardial sac, short of hydro-pericardium, old adhesive bands uniting the visceral and parietal layers of the pericardium, or “milk-spots” of varying size over the surface of the heart, are the conditions most commonly found. According to the above table, 27·91 per cent. of the total presented evidences of having had pericarditis at one time or another. This percentage is considerably above that of Dr. Howden,† who found changes of the pericardium in 18·3 per cent. of his cases.

It would appear that in the mental condition where hypertrophy of the heart is most common pericarditis occurs with greater frequency; in other words, pericardial changes were found in 37 per cent. of all the cases suffering from mania. It is difficult to say whether the pericarditis is consequent on the hypertrophy or the converse.

(6.) *Valvular Lesions of the Heart*.—In this column are

* “Journal Mental Science,” Vol. xvii., p. 92.

† *Op. cit.*, p. 88.

recorded all the cases of disease or abnormality of the valvular apparatus of the heart, and it is interesting to note that although 13·51 per cent. died from heart disease, 77, or nearly 34·7 per cent. of the total, had disease of one or other of the valves. This proportion is somewhat above that of Dr. Howden, who found the valves abnormal in 25·5 per cent. of his cases, and of Dr. Burman, who states that in his autopsies the valves were diseased in 27·2 per cent. Dementia was the only mental condition in which affections of the aortic valves were more common than those of the mitral orifices. Although heart disease as a cause of death in general paralysis is comparatively uncommon, the valves, more especially the mitral, were found diseased in fully one-third of the cases examined. In this disease the aortic valves were seldom incompetent, although there occurred frequently a roughened condition of the cusps and the lining membrane of the aorta, and the lower portion of the aorta itself was frequently found considerably dilated.

(7.) *Arterial Disease in the Insane*.—In this place I will refer only to such naked-eye appearances as are met with in the post-mortem examinations, reserving the microscopic appearances found in the cerebral blood-vessels for the second portion of this paper.

Thickening or atheroma of the walls of the arteries is comparatively common among the insane, and when this condition occurs in the cerebral arteries it exercises an important influence on the functions of the brain. If the lumen of the vessels is constricted the brain receives a diminished supply of nourishment, the blood-pressure in the brain is increased, extra work is thrown back on the heart to overcome the resistance, and this results ultimately in cardiac hypertrophy. It will be thus seen that there exists a close connection between arterial degeneration and hypertrophy of the heart. Atheromatous degeneration or thickening of the vessels is a condition which occurs naturally in old age, but, as will be seen by a reference to the following table, age appears to exercise a less influence over the state of the blood vessels in the insane than in the sane.

According to the following table, atheroma of the arteries appears most frequently between the ages of 50 and 60, if we exclude cases above 75 years of age, when atheromatous degeneration is almost constant. With the exception of general paralysis, it does not occur frequently before the age of 50; in this disease thickening of the coats or atheroma of the vessels occurs at an early age, and there can be no

doubt that this change is to be regarded as a pathological condition occurring as a result of the morbid process of the disease.

TABLE VIII.—Showing the age and percentage of patients who had evidence of distinct atheromatous disease of their arteries after death.

Age of Patients at Death.	Total No. Examined.			Mania.		Melancholia.		General Paralysis.		Epilepsy.		Dementia.		Imbecility.		Total No. presenting Atheroma.			Percentage on Totals.
	M.	F.	T.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	T.	
20 under 30 ...	11	2	13	...	...	...	...	1	...	...	...	...	...	...	...	1	...	1	7.69
30 „ 40 ...	24	14	40	2	1	...	1	4	2	...	...	...	...	...	...	6	4	10	25.00
40 „ 50 ...	26	17	43	3	...	...	1	4	4	3	...	...	...	...	...	10	5	15	34.83
50 „ 60 ..	27	14	41	4	6	2	1	6	2	3	...	3	...	1	1	19	10	29	80.48
60 „ 70 ...	22	20	42	7	9	3	4	...	...	...	3	2	3	1	...	13	19	32	76.11
70 „ 80 ...	19	17	36	6	8	5	1	...	...	...	...	6	3	...	...	17	12	29	80.55
80 upwards ...	5	2	7	4	2	2	1	...	...	...	...	...	...	...	...	5	2	7	100.00
Totals & Average.	126	86	222	26	26	11	8	15	8	6	3	11	6	2	1	71	52	123	55.4

Of the 123 cases presenting atheroma of the vessels, 31 males and 19 females had valvular disease or other morbid conditions of the heart, while only 16 cases (9 males and 7 females) had atheroma of the vessels, but presented no cardiac disease.* Of the 50 cases of heart disease associated with atheroma, one male suffered from Bright's disease as well; there were two cases of cardiac hypertrophy alone without any valvular lesion, and three cases of extensive pericardial effusion. According to the above statistics atheroma appears to occur more frequently (71) in males than in females (52).

(5). *The Percentage of Deaths from Heart Disease or Arterial Change among the General Public.*

I regret that the limits of this paper and the time at my disposal prevent me bestowing sufficient attention on this portion of my observations, particularly as it is more by a

* Hitchman (quoted by Griesinger, p. 417) found atheroma of the cerebral vessels in 37 females of 97 autopsies on insane subjects. A percentage of 38.1.

study of the relative frequency of heart disease among a sane population and an asylum community that a true comparison can be instituted.

The observations which follow are founded on Public Health Reports, Pathological Registers, and the Registrar-General's Returns.

(1.) Infirmary, which during four years (1881-84) had 2,445 cases under treatment.

(2.) City (Health Reports), representing a population of 37,000, and an annual death rate of upwards of 700.

(3.) Middlesex Hospital (Pathological Reports), with a description of the appearances found in 568 autopsies during two years.

(4.) Registrar-General's Returns (Scotland, 1881), with a total mortality of 72,325.

In all the cases where a percentage of deaths from heart disease has been obtained from a population of mixed ages, 20 per cent. of the total has been deducted to allow of those deaths under 20 years of age,† as below this heart disease is rare as a cause of death, and also to bring the statistics more into comparison with an asylum population.

(1.) Of the 2,445 cases treated at Infirmary during the four years under review, 75 suffered from heart disease, and 19 were under treatment for cardiac functional disorders or arterial diseases, a percentage of 3·83 and ·097 respectively. Few autopsies are, however, allowed in this institution, and a pathological register is not published.

(2.) City. From the report issued by the medical officer of health I find that, during the year 1883, 779 deaths occurred, and that of these 84, or 13·46 per cent., were due to heart disease. During the following year 783 deaths were registered, and 72, or 13·4 per cent., were ascribed to heart disease; three deaths only were said to be due to arterial disease.

(3.) In the Middlesex Hospital during the two years 1881-82, 568 autopsies were made, and of these 53 deaths, or 9·25 per cent., were ascribed to heart disease; and 106, or 16 per cent., presented lesions of the heart or vessels occurring as a secondary factor in the fatal issue. There were 2,086 admissions during the two years under review; 161 were known to have had heart disease, and 42 individuals suffered

† According to the Registrar-General (England, 1884), 19·1 per cent. of the total deaths occur under 20 years of age.

from some functional cardiac disorder, percentages of 7·7 and 2·01 respectively.

(4.) From the Registrar-General's Annual Return (1881) I find that 72,325 deaths were registered; disease of the heart ended fatally in 4,840 cases, a percentage of 8·36 of the total; it is interesting to note that heart disease is more fatal on the mainland and in rural districts than in the insular districts, where it was responsible for only 6·22 per cent. of the total deaths.

Taking the average of the above statistics, it is found that 8·72 per cent. of the total deaths among a sane population is ascribed to heart disease.

In this asylum the death rate from heart disease is only a fraction above the death rate from the same cause in the neighbourhood; but, according to the above statistics, heart disease is more frequent in this county, and at the same time the ratio of the insane to the sane is greater than in many other counties, as it occupies a position in the upper group of the table used by Dr. Burman, and previously referred to.

(6.) *General Summary and Conclusions.*

The following are the conclusions at which I have arrived from a consideration of the preceding observations:—

(1.) That heart disease occurs with greater frequency among the insane than among the sane.

(2.) That this increase in frequency is in part regulated by the frequency of heart disease among the sane population in the vicinity of the asylum where the observations are made.

(3.) That heart disease is more frequent among the insane in the counties where the ratio of the insane to the sane is greatest.

(4.) That the distribution of heart disease among the sane is regulated by the geographical position, dietetic and other influences acting as predisposing causes. Similar conditions appear to exercise an influence over the frequency of heart disease in the insane.

(5.) That the numerical difference between heart disease in the sane and the insane, if considered over all, is not great, being 8·72 per cent. of the total deaths in the former, and 9·36 per cent. in the latter.

(6.) That, according to my observations conducted in this asylum, heart disease is present in 12·94 per cent. of the living insane, and is the cause of death in 13·51 per cent.

Both on admission and at death the age of the greatest number who had heart disease was between 60 and 70.

(7.) That the clinical symptoms of mitral regurgitation in the living insane, and mitral disease with left-sided hypertrophy post-mortem, are the most common affections.

(8.) That the hearts of the insane are heavier than those of the sane, and this condition is more especially noted in general paralysis, where the heart is very frequently hypertrophied.

(9.) That in many cases of insanity the general circulation is sluggish, and the extremities are cold, livid, or even swollen. This condition occurs most frequently in cases of chronic or advanced types of insanity.

(10.) That the arteries are frequently affected in the insane, but that, with respect to the age, atheromatous degeneration of the arterial coats does not appear to occur earlier than among the sane. In general paralysis, however, thickening of the arterial tunics, or even atheromatous degeneration of the cerebral arteries, occurs quite independently of the age of the patient, and appears to be influenced more by the duration of the disease than by the age.

(11.) That, among the sane, heart disease appears to exercise an important influence on the mind, changing the temperament and altering the character of the patient, and that this change may become so prominent that the psychological phenomena exhibited may be those actually of insanity.

(12.) That, not only does heart disease alter the type and delusions of insanity, but also some cases occur among the insane, in whom the only ascertained predisposing cause of the mental aberration is the diseased condition of the heart, or general derangement of the circulatory system, and that, in these cases, the cardiac lesion is, no doubt, the predisposing cause of the insanity.

II. *Pathological Division.*

The following observations are founded on the microscopic examinations of 16 brains, taken in sequence; in four of these the vessels were dissected out from a given portion of the brain, and in the remaining 12 cases two portions of the brain—the right ascending parietal convolution and the corpus striatum—were removed and hardened preparatory to sections being made. Upwards of 140 sections were selected from these different portions, and the drawings which accompany this paper were taken from those specimens which

presented any peculiarities in the course or the structure of the vessels. These drawings were all done by the writer.*

The mental condition of the patients, whose brains I examined, was as follows:—Dementia, eight—four of whom were cases of senile decay; epilepsy, two; general paralysis, three; paralytic insanity, one; *folie circulaire*, one; and congenital imbecility, one. Three of these 16 cases had extensive organic disease of the heart.

Previous to detailing the changes which were observed in these cases, I propose to describe briefly the normal structure of the cerebral vessels according to the latest observers and from my own investigations.

Structure of the Vessels of the Brain in Health.

The medium-sized arteries of the brain are said by most authorities to possess four coats—the endothelium, the membrana fenestrata, the tunica muscularis, and the tunica adventitia. Th. Deecke† has described two, and, in many of the larger vessels, three additional tunics.

(1.) *The Endothelial tunic* is the innermost lining membrane of the arteries, and is continuous throughout the whole vascular system. In the arteries it consists of a layer of flattened endothelial cells, the outlines of which can be demonstrated by the ordinary silver process. The nuclei of these cells are oval or elongated in shape, and arranged with their long axis corresponding to the long axis of the vessel.

(2.) *The Membrana fenestrata* is a non-nucleated, irregular and reticulated web of compact bands, in which minute bright spots are seen, stated to be foramina by Deecke. They are generally found immediately above or in the neighbourhood of the nuclei, belonging to the subjacent endothelial tunic, are round in shape, and so small that a high magnifying power is requisite in studying their characters.

(3.) *The tunica Muscularis* consists of bundles of circularly-arranged, unstriated muscular fibres, and the thickness of the vessel as a rule depends on the number of these fibres present. Their nuclei are oval in shape, arranged transversely to the long axis of the vessel, and stain well with carmine. Interwoven with the muscular fibres are elastic bundles and connective tissue corpuscles whose peculiar-shaped nuclei are well seen in carmine-stained preparations.

(4.) *The tunica Adventitia* (the seventh layer of Deecke) is

* Only a few of the drawings can be published.—Eds.

† "American Journal of Insanity," July, 1877.

composed of broad connective tissue elements, in health generally lying in close apposition to the subjacent coat, with slight dilatations here and there, and it is only in pathological conditions that it is extensively separated from the muscular coat forming the "adventitial lymph space" of Virchow and Robin. The nuclei of its outer layers are oblong and more rounded in shape in its inner layers.

The *Perivascular Space* is the interval between the adventitia and the brain tissue; in the healthy condition it is not extensive. Obersteiner* states that he observed numerous lymphoid corpuscles within it, but whether they were of the nature of wandering leucocytes he is unable to decide. The perivascular spaces, "the lymph ducts" of His, have no definite wall, but are lined by the brain tissue, and, according to Obersteiner, communicate with the "pericellular spaces" which surround the large ganglion cells of the brain. They are supposed to be lymphatic channels through which the neurine receives its proper nourishment. Dr. Batty Tuke† considered that this space was an abnormal condition, but at the same time he recognises "a pure hyaline membrane forming a somewhat loose envelope to the vessel" in healthy brains.

Structure of the Capillaries and Veins.

The *Capillaries* consist of two tunics, the internal of which is a delicate endothelial membrane, a continuation of the lining membrane of the arteries and the veins; and the external or adventitial sheath, firmer here, however, than in the arteries or the veins.

The *Veins* possess three coats, an internal endothelial tunic, a middle coat consisting of bundles of connective tissue, and an external adventitial sheath.

It is thus seen that the tunica adventitia surrounds the whole of the circulatory system in the brain, even to the most minute capillaries, leaving a space between it and the subjacent coat, more or less theoretical in the larger arteries, but in the smaller vessels forming in places a loose enveloping membrane.

Changes in the Blood Vessels of the Insane.

General Paralysis: In this disease, the morbid process of which is said to originate in the vascular system of the brain

* "Brain," October, 1884.

† "British and Foreign Medico-Chirurgical Review," Vol. cii., p. 873.

according to recent authorities, numerous important pathological changes were observed both in and around the vessels.

In small arteries which were traced from the pia mater inwards some considerable distance in the convolutions, I found a slight degree of tortuosity, and in places localised dilatations, but neither of these conditions occurred to the extent usually described in this disease. The vascular walls were generally thickened, more, however, from hypertrophy of the muscular coat than by atheromatous deposits. The adventitial sheath formed a loose enveloping membrane to the vessel and all its branches, with wide spaces at the points of bifurcation, and here and there along the course of the artery bulging out, leaving a considerable interval between the vessel and its sheath. Within and upon the sheath, more especially at the angles caused by the bifurcation of the vessel into two smaller branches, were deposited small particles of pigment and minute globules of fat. The pigment varied in colour from a pale primrose tint to deep brown mahogany. Obersteiner states that the paler varieties of pigment are in all probability metamorphosed fat granules, and this statement received some support from the action of osmic acid, which blackened the pale varieties, while those of a darker tint remained unaffected by the reagent. I experienced considerable difficulty in making satisfactory sections from the hardened brains of paralytics; this was due to the brittle and peculiar sieve-like appearance the section had. Under the microscope this condition was recognised as being due to numerous spaces which were considered by Lockhart Clarke* to be perivascular spaces from which the blood vessels had either dropped out or remained in a shrivelled up condition.

In general paralysis the perivascular spaces were enormously distended, and their outline was irregular and rugged. The nuclei of the adventitia were proliferated, and the walls of the vessels had a hypertrophied appearance. In the case of a male paralytic who succumbed to a series of epileptiform fits, the *veins* were filled with red blood corpuscles, and there was an extensive proliferation of the nuclei of the venous coats, the veins themselves being considerably distended.

Paralytic Insanity.—This was a male, aged 61, who

* Quoted "Journal of Mental Science," Vol. xv., p. 500.

was paralysed, and at intervals bedridden for upwards of three years, and although some of the clinical features were those of general paralysis, and the pathological appearances of the cerebral membranes were similar to those generally found in this disease, yet the microscopical examination of the cerebral arteries presented none of the conditions which I have found common in general paralysis. The adventitial sheath was in close apposition to the sub-jacent tunic, with the exception of the parts at the point of division of the vessels, when it became loose and bridged over from one branch to the other, forming a triangular space which contained numerous fat and pigment granules. The arterial coats, more especially the muscular tunic, were considerably thickened, and small calcareous crystals were deposited on the adventitia. Osmic acid stained the muscular fibres to so deep an extent as to indicate the presence of fatty degeneration of the muscular fibres, a condition, according to Obersteiner, not uncommon in old subjects.

Dementia (Senile).—A study of the condition of the blood-vessels in an advanced stage of cerebral atrophy is full of interest, and I have been fortunate in securing four brains illustrating this condition. These were from three females, aged 82, 80, and 76 respectively, and one male, aged 75. In this condition of old age the brain was generally found water-logged, the arteries very atheromatous, the convolutions much atrophied, and the brain on section softer than normal. Microscopically the perivascular spaces in all were considerably distended, and contained large quantities of pigment granules. In one specimen these pigment granules were large, round, in places isolated and apparently within the muscular tunic, others were united in the form of masses—mulberry-like—and lying upon the outer coat of the vessel. In all these cases, on transverse section of the vessels, the tunica muscularis was extensively hypertrophied, the lumen of the vessel diminished, and the tunica intima had a wavy appearance. In longitudinal sections the intima presented a peculiar roughened or “ground-glass” appearance, and in places had deposits of globular bodies, which stained well with carmine, regarding the nature of which I am still uncertain. The arteries generally had a hard, brittle appearance, their outline was irregular, and in places notched. The tunica adventitia in a female dement, aged 80, hung much looser round the arteries, especially the smaller vessels, than is usually the case, and

the space between the adventitia and the muscular coat contained bright crystals of lime salts. In a male dement, aged 75, the perivascular spaces were large, but their walls were smooth, and they did not present the rugged outline found in general paralysis. E. C., a female, aged 37, suffering from secondary dementia, had a severe attack of hæmatemesis, during which she died, and at the autopsy a large aneurism of the abdominal aorta was found, which had ruptured into the upper portion of the small intestine. The skull cap presented a small bony protuberance over its frontal portion. There was no history of specific disease. On examining the cerebral arteries I found their walls considerably thickened, due to a cellular infiltration immediately underneath the tunica intima bulging out this coat in places—an appearance described by some authors as essentially syphilitic in nature. There were minute spindle-shaped aneurismal dilations in several of the vessels, and many of the arteries were filled with red blood corpuscles.

In another case of secondary dementia with extreme mitral stenosis and cardiac hypertrophy, I found a condition of the blood-vessels, which I can only ascribe to the effects of the cardiac disease. The cerebral arteries were tortuous, and in some cases so twisted as to be almost bent upon themselves, this condition necessitating dilatation of the perivascular spaces; the walls of the arteries were also considerably hypertrophied.

Epilepsy.—The changes in the blood-vessels of the brain in epilepsy are not conspicuous, and are similar to those generally found in long-continued cases of cerebral congestion. In a female epileptic imbecile, aged 27, who died from a series of fits, the muscular coat of the cerebral arteries was thickened, the veins considerably distended, their walls hypertrophied, and their lumen choked up with red blood corpuscles. There was extensive pigmentary deposit external to the vessels, and within them were minute dark granular bodies, evidently fatty in nature. The large ganglion cells of the brain were atrophied and in an advanced stage of pigmentary degeneration for a patient so young. The other case of epilepsy examined was that of a male, aged 45, who died from phthisis, and here, with the exception of slight hypertrophy of the tunica muscularis, and deposits of fatty granular matter within the arteries, little change of a pathological nature was observed. In both these cases, although the perivascular spaces were somewhat distended,

the adventitial sheath was, for the most part, in close contact with the subjacent tunic.

There is a form of brain disease associated with paralysis which occurs occasionally among the insane, and invariably ends fatally, and the naked-eye appearance of the brain appears normal. The clinical symptoms in some respects are similar to some forms of general paralysis, and the microscopic appearances of the brain are closely similar to what I have found in this disease. The following is a brief description of a typical case:—M. B., female, aged 43. Her mental condition was that described by authors as *folie circulaire*. About a week previous to her death she became dull, stupid, and impaired in her gait after an attack of excitement. In walking she staggered and trailed her limbs. She rapidly became worse, the paralysis increased, and her temperature rose. She had several attacks of an epileptiform character, and after each attack the paralysis was more pronounced. The ordinary reflexes disappeared, and she had extreme dysphagia for some time before her death.

At the autopsy the skull-cap was found thickened, the membranes congested, and there was slight subarachnoid opacity, especially over the parietal convolutions, which were atrophied. Other than these changes the brain presented nothing abnormal to the naked eye.

Sections of different portions of the brain were examined under the microscope. The minute arteries were thickened from hypertrophy of the muscular tunic, and proliferation of the nuclei of the adventitia was a very marked condition. The arteries in many portions, especially in the basal ganglia of the brain, were tortuous, and presented here and there minute dilatations from localised paralysis of the muscular fibres forming the muscular coat. The perivascular spaces were increased to a considerable extent, and there was extensive pigmentary deposit in and around the vessels. The matrix of the brain contained, in addition, dark brown granules of hæmatoid in the neighbourhood of some of the vessels. The cells, both of the cortex and basal ganglia of the brain, were considerably atrophied, and had undergone extensive fuscous degeneration, the nuclei in many had disappeared, and were replaced by little round granules of pigment united in masses. The cell processes in many of the specimens were either much shortened or had entirely disappeared.



Fig. 1



Fig. 2

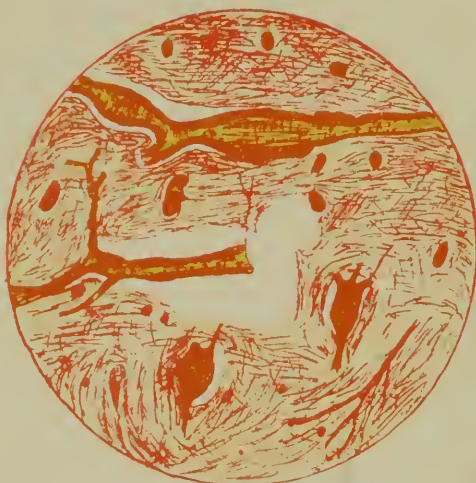


Fig. 5



Fig. 3



Fig. 4

REFERENCE TO PLATES.

PLATE I.

Fig. 1.—Minute cerebral artery, showing the structure of the different coats. \times over 800.

Fig. 2.—Portion of small cerebral artery, showing the tunica adventitia in close apposition to the subjacent muscular coat. \times 350.

Fig. 3.—Artery from brain of male general paralytic; contour irregular; adventitia hangs loosely round the vessel, and there is a pigmentary deposit, especially in angles, caused by the bifurcations of the artery. \times 350.

Fig. 4.—Artery from brain of senile dement, aged 80; muscular coat thickened; adventitia loosely surrounds vessel, and contains, in addition to pigment deposits, small club-shaped crystals of lime salts. \times 350.

Fig. 5.—Section of corpus striatum of male paralytic, showing ampullations of arteries, dilated perivascular spaces, and atrophy and pigmentary degeneration of the cells. Stained in picrocarmine and \times 500.

PLATE II.

Fig. 1.—Section of right asc. pariet. convol. from a female with extreme mitral stenosis, showing peculiarly twisted and tortuous condition of a small artery. \times 500.

Fig. 2.—Section of corpus striatum from a male general paralytic, showing proliferation of nuclei of muscular tunic of arteries, with atrophy and pigmentation of cells. \times 500.

Fig. 3.—Section of right asc. pariet. convol. from brain of *M. B.* (*vide* page 354), showing ampullated and tortuous condition of arteries, proliferation of nuclei, and yellow pigmentation of cells—appearances similar to those found in cases of general paralysis. \times 700.

Fig. 4.—Section of right asc. pariet. convol. from a senile dement, aged 76; stained in picrocarmine and cleared up by oil of cloves; arteries are atheromatous, their outline is irregular; perivascular spaces much dilated; and a "ground-glass" appearance of intima. \times 500.

Fig. 5.—Section of corpus striatum from female, aged 82, showing branch of artery compressed by patch of sclerosis; tunica muscularis thickened, and presents large yellow globules; within the lumen of vessel are collections of small round granules, which stain well with carmine. \times 500.

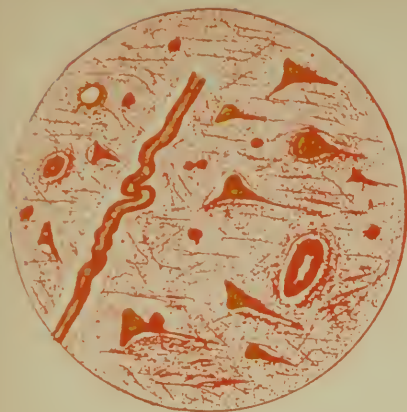


Fig. 1

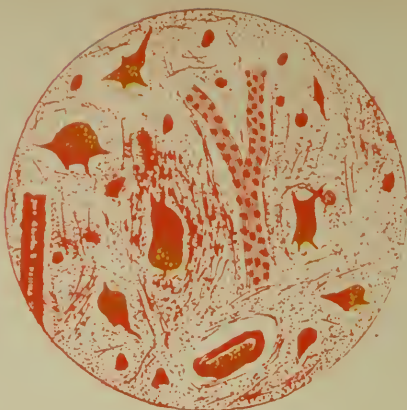


Fig. 2

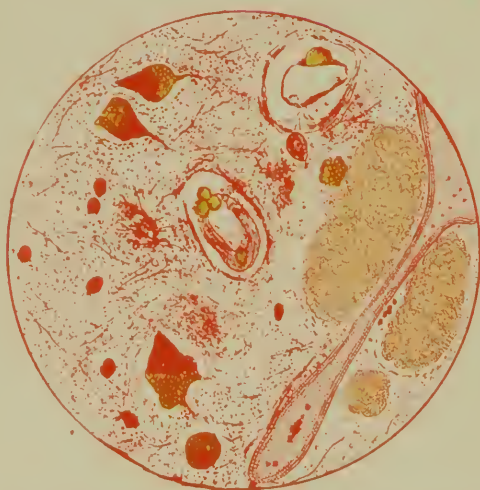


Fig. 5

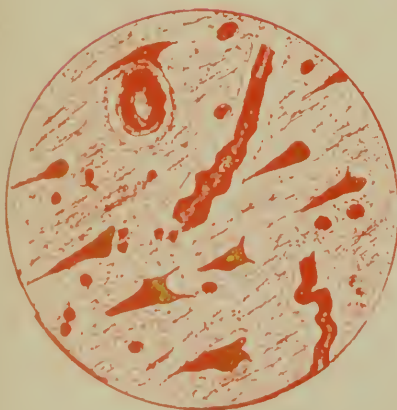


Fig. 3

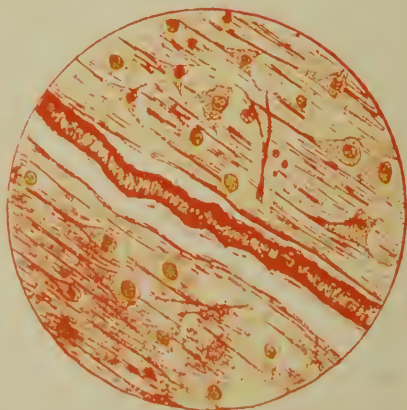


Fig. 4

Many of these appearances are identical with those described in connection with general paralysis, but until I have examined the spinal cord in other cases of a similar nature I must refrain from arriving at a conclusion as to the true pathology of this disease.

Sane or Insane ? By F. NORTON MANNING, M.D., Inspector-General of Insane in New South Wales.

A. B., a prisoner with two or three aliases, aged 40, strongly-built, of short stature, with dark complexion and pock-marked face, was admitted into the observation ward at H.M. gaol, Darlinghurst, early in August, 1884, with the following history. He had served one sentence certainly, and perhaps more, in the neighbouring colony of Victoria, was reported to be an old offender, and was sentenced to seven years for arson in U.S.A., in March, 1884. He was sent at once to undergo the usual nine months' solitary and separate treatment with which all long sentences commence in Berrima—the special gaol set apart for this—and at the beginning of May was reported by the visiting medical officer of that gaol as unfit for this treatment, because he was an epileptic.

Late in June—some delay having occurred owing to the closure of an old and the opening of a new gaol—he was sent to Goulburn, where the prisoners sleep and work in association; and from there he was sent to the observation ward above mentioned, with a report from the visiting medical officer that he suffered from frequent and severe epileptic fits, that his mind was becoming affected, and that he was at times violent and troublesome.

The observation ward is set apart by Statute for the special care of prisoners showing symptoms of insanity whilst undergoing sentence; and before any prisoner can be removed from it to the asylum for insane criminals, one of the medical certificates must be signed by an officer of the Lunacy Department.

After a short residence in this ward, the medical officer reported that the prisoner was exceedingly violent and troublesome, and requested that he might be specially examined with a view to being sent to the criminal asylum. I undertook this duty myself, and I signed one medical certificate—the other being signed by the medical officer of

the gaol—on the following grounds. The man was reported as epileptic by two gaol medical officers, each after somewhat lengthened charge of the case. I saw a very curious and incoherent letter written by the prisoner, in which there was repeated mention of Dr. Dick, formerly medical superintendent of Yarra Bend Asylum, and now inspector of asylums in Victoria, from which colony the prisoner came to New South Wales, and which led to the inference that the prisoner had been in one of the Victorian asylums. In the same letter was a statement that prisoner was entitled to considerable property by the death of his uncle, the under-secretary of one of the Public Departments, a gentleman who was still alive, and denied all consanguinity. The prisoner, at the time of examination, had two bad black eyes, received in a fight with one of his fellows. He was reported as extremely and suddenly violent, so turbulent as to keep the ward in disorder, and when quiet morose, sullen and taciturn. I found his memory apparently impaired, his answers were inconsequent and rambling, and the delusions mentioned in the letter were repeated. His manner was sullen and angry. He was very uncommunicative, and I could gather no information from him as to his history in Victoria. There was, in addition, the evidence of the warders and fellow prisoners that he was noisy and sleepless at night, and for two nights at least had slept scarcely at all. The warder in charge, a man of considerable experience and intelligence, believed him to be insane, and, with the medical officer, was anxious for his removal owing to the great trouble he caused. It should be stated that he was not noticed to have any fits whilst in the observation ward, a period of 12 or 14 days. The strong points in the case were the sequence of symptoms: the violence, loss of memory, &c., following epilepsy, and the sleeplessness.

The prisoner was transferred to the asylum for insane criminals at Parramatta, and for some time no doubts were raised as to his mental condition. The case-books describe him as silent and sullen, liable to outbreaks of violence, occasionally aggressive, and as having delusions—among them being that his clothes were poisoned, and that they were worn by the attendants. Later on he is described as quieter, better tempered and more amenable; and then, after more than four months' residence, a suspicion that he was malingering was expressed. It was noticed that he could talk sensibly and at length to the more intelligent patients, but was reticent with the attendants; and when specially ex-

amined by the medical officer, appeared dazed and stupid, and spoke of a number of delusions. He slept well, and it was remarked that he had not had an epileptic fit since admission. The suspicion was strengthened by further observation, and by some information which reached the medical superintendent, Dr. Godson, that he was, with another patient, planning an escape. A special report was made to me on this subject, and I examined him on March 2nd, with the medical superintendent and the assistant medical officer present. In his anxiety not to be sent back to gaol he overdid matters, and, in answer to enquiries, stated that he did not know his crime, his sentence, or how long he had to serve, and was unaware that he had ever had fits. His expression was heavy, and he evidently wished to appear demented. The interview taken in connection with Dr. Godson's reports left no doubt in my mind that he was malingering, but I thought it advisable before directing his return to gaol to make further enquiries as to his prison history.

Two days after my examination he attempted the escape, for which all arrangements had evidently been planned at the time of this examination. He had sawn through the iron framing of his window, replaced the piece sawn out by soft putty used for mending a broken pane, arranged how to get clothes, and, in fact, displayed very considerable cleverness; but it was defeated by his inability to get through an outer grating, a feat which a less muscular man could have managed, and by his inability to file away this—even if he then possessed the saw, which is doubtful—owing to an additional night attendant being on duty close at hand to frustrate the attempt. When he failed to get away, he replaced the sawn frame with putty, and in the morning accounted for scratches and bruises on his legs and body—evidently caused by a desperate attempt to squeeze through the too narrow opening—by the statement that he had *had a fit in the night*. When shown the sawn frame and asked for the saw—which was evidently of the finest kind, and was never discovered—he was evidently much chagrined, and broke out into violence and abuse.

A closer examination of his prison history and papers disclosed the following facts. The arson of which he was convicted followed an insurance on a small house, which had been effected with considerable cleverness; the risk having—owing to his adroit management—been taken by the insurance officer without any preliminary examination of the premises. There was no evidence of any epileptic fits until

an attempt to re-open his case and to get his sentence commuted, on the ground that he had not been able to call important witnesses, had been made by him and had failed. Neither of the medical officers at Berrima or Goulburn Gaols had seen him in a fit, but had taken the reports of warders and prisoners. Dr. Dick had no knowledge of him under any of his aliases, or from his description, and though he was known in the Victorian prisons it seemed certain that he had not been in any asylum there. A re-examination of the letter containing Dr. Dick's name seemed to render it almost certain that it was written "with intent to deceive." For some days after his attempt to escape he was angry and sullen, but he recovered his spirits, talked to the attendants, and seemed to think the matter had blown over. On March 2nd he was sent back to Darlinghurst Gaol, and reported as a malingerer, and thirty hours after, he committed suicide by strangulation.

At the inquest the medical officer of the gaol stated that he closely examined B. on his return, and considered him sane. In the course of conversation he informed him that he was considered to be a malingerer, advised him to behave properly and not to give trouble to the gaol authorities, and warned him that any further misbehaviour would lead to punishment. The prisoner, who promised to give no trouble, was placed in a cell about 12ft. by 8ft., with two others, and about seven p.m. these two were alarmed by a choking sort of noise, and on examination found Barry with the rope of his hammock round his neck, and the end of it fastened to the eye in the wall used for slinging the hammock. Assistance was summoned and the rope removed, when the prisoner grumbled and said he was all right. His hammock and bedding were returned to him, and he appears to have slept. In the morning he was reported as malingering, and after a re-examination by the medical officer, who saw nothing to induce him to think him insane, was placed in a cell by himself to await punishment, after examination by the Visiting Justice. He was seen repeatedly during the day by the dispenser and other officers, took his food, and spoke rationally. His hammock and bedding were given to him at quarter past four p.m., and at quarter past five he was found dead, the cord of the hammock round his neck, and the end fastened to the bar of the iron gate of his cell. The opinion of the whole of the prison officials was that he had not intended to kill himself, but that on both occasions his intention was to keep up the idea that he was still insane.

They pointed out the fact that the attempt made at seven o'clock at night, with two other people in a cell 12ft. by 8ft., and so close as to almost touch him, was certain to attract attention, especially at that early hour, and that there had been no further attempt during the night, when, the other prisoners being asleep, it might have been more successful, and they showed also that the attempt which resulted in death would probably not have succeeded except for an accident which disturbed the gaol routine and postponed the usual official visitation from a little before five to a quarter past five o'clock—their view being that he put the rope round his neck a little before five, knowing the gaol routine, and expecting to be visited at or about that time.

This may have been the case, but on a consideration of the whole circumstances I am inclined to think that the suicide was deliberate and intentional; that, being a man of great determination of character, finding himself back again in gaol with six years more to serve, with all his labour and pains thrown away, and all chance of escape or of mitigation of sentence gone, he simply “threw up the sponge,” being at the time thoroughly responsible for his actions.

The Coroner, who, in the course of the enquiry, remarked that suicide was no proof of insanity, summed up at its close with cynical brevity, and told the jury that whether the man was sane or insane mattered very little; the only point they had to consider was whether he hanged himself or somebody else hanged him, and the jury promptly found a verdict that he hanged himself.

It need hardly be said that the task of reporting this case is not a pleasant one, since, whether the man was sane and a malingerer, or insane and irresponsible, it is quite clear that I committed a grievous mistake. It is of course possible that this man was insane when certified, and that the malingering commenced only in the asylum after convalescence, and when he saw that the chances of escape were greater there than in gaol, but I cannot adopt this view. In the view that I now take, this mistake consisted in certifying to insanity without such full and deliberate examination as was necessary, and in accepting evidence of epilepsy without full enquiry. It is always advisable to make at least two examinations of insane prisoners before certifying, and in acting in this case after one examination I departed from a usual custom. The evidence as to epilepsy in these cases should consist of the direct testimony of a skilled witness. The length of time for which prisoners will keep up sham

epilepsy, the completeness with which they will imitate the phenomena of the attacks, and the sufferings they will undergo to carry their point, are well illustrated in a case admirably told by Dr. Carlos MacDonald in the "American Journal of Insanity" for July, 1880. The fact that suicide is not inconsistent with sanity is curiously illustrated by a case which occurred in Sydney within the last few days. A middle-aged, intelligent artisan, a confessed "free thinker," who had repeatedly when in good health asserted that he would commit suicide rather than suffer a lingering death, was admitted into one of the general hospitals with dropsy due to hepatic and other mischief. During a residence of two or three weeks there was not the smallest reason to think him otherwise than thoroughly sane and intelligent, and his ailment did not in any way seem to affect his mental condition. At the visits of his wife he discussed the chances of recovery, told her quietly that if he ascertained from the doctor that his case was hopeless, he should commit suicide, and said he had thought of asking her to bring him a pistol, but considering that this would be a cruel shock to his fellow-patients in the ward, he would not adopt this method.

One day, soon after this conversation, he learned on enquiry from one of the resident medical officers that his case was a hopeless one. He watched his opportunity, went out on to a balcony outside the ward, which was on the second story, deliberately flung himself over on to some stone steps and broke his neck.

CLINICAL NOTES AND CASES.

Case of Moral Insanity or Congenital Moral Defect, with Commentary. By D. HACK TUKE, M.D.

Read at the Annual Meeting of the Medico-Psychological Association, held at Cork, Aug. 4, 1885.

When I was at the Kingston Asylum, Ontario, last August, a male patient had just escaped from the institution, and made a criminal assault upon a little girl in the neighbourhood. From the inquiries I made, I found that the case was one of much interest in its bearing on moral insanity (or imbecility), and I was allowed to read the notes in the well-kept case-book of the asylum. Dr. Metcalf, the medical superintendent, has very kindly permitted me to make use of them,



CASE OF MORAL INSANITY.

and the further particulars of this patient's history and acts, which he has given me. A photograph was subsequently taken, which I have had reproduced by the London Auto-type Company. (See Plate.).

W. B. was born at Swansea, Wales, on 26th June, 1843. In his tenth year he emigrated to Canada with his father, stepmother, and brothers. He was not known to his stepmother until about a fortnight before leaving for Canada, as he had been away at school. His stepmother states that he has been of a sullen disposition ever since she has known him; uncommunicative, idle, sly, and treacherous; that at an early age he evinced a disposition to torture domestic animals, and to cruelly treat the younger members of the family.

On one occasion he took with him his young brother, a lad five or six years of age, ostensibly to pick berries, which grew wild, not far away. On arriving at a secluded spot, he removed the clothes from the child, and proceeded to whip him with long lithe willows, and, not satisfied with this, he bit and scratched the lad terribly about the arms and upper part of the body, threatening that if he made an outcry he would kill him with a table-knife, which he had secretly brought with him. The cries of the boy attracted the attention of a labourer, who promptly came to the rescue, and in all probability saved the little fellow's life. Shortly after this act of cruelty to his brother, B. was apprehended for cutting the throat of a valuable horse belonging to a neighbour. For some little time prior to this act, considerable anxiety had been felt by people in the neighbourhood where B. lived, for their live-stock. Horses were unsafe at night in the pastures, as several had been found in the mornings with wounded throats. In the stables they were equally unsafe, as a valuable beast was killed in its stall in broad daylight. About this time, also, people in the neighbourhood observed an unaccountable decrease in the number of their fowls. When B. was apprehended for cutting the horse's throat, he confessed that he not only did this vile act, but also that he had maimed the other animals to which reference has been made, and that he had killed the fowls, twisted their necks, and then concealed them in wood piles, &c. For these offences he was sentenced to twelve months in gaol. When he returned home after serving out his sentence, his family were more suspicious of him, owing to past experience, and he was more carefully looked after. He was watched during the day, and locked in a separate room at night. These measures were necessary to protect the family, as he had made an effort to strangle a younger brother while occupying a dormitory with him.

One day, soon after his discharge from gaol, B.'s stepmother left a little child asleep upstairs while she proceeded with her household duties, not knowing that B. was in the house. In a short time afterwards she was informed by one of the other children that the baby was crying, and on going to the room where she had left the sleeping

baby, she discovered that it had disappeared. B. had taken the little child to his own room, put it in his bed, and then piled a quantity of clothing, &c., on top of it. When rescued, the child was nearly suffocated, and was revived with difficulty. Immediately after this attempt to suffocate his baby sister, B. abstracted a considerable sum of money from his father's desk, and attempted to escape with it; he was recaptured, however, and the money taken from him. For this offence he was tried, found guilty, and sentenced to serve seven years in the Penitentiary. While serving out this sentence he was transferred to the criminal asylum connected with the prison, but on the expiration of his sentence he was discharged. On being released he crossed over to the United States, and enlisted in a cavalry regiment. In consequence of the horse assigned to him not being a good one, he was obliged to fall behind on a march, and, taking advantage of this, a favourable opportunity offering, he drove this animal into a deep morass, and belaboured the poor beast until it was fast in the mire, there he left it to its fate, and it was found dead the next morning. B. now deserted, and after undergoing some hardships, again returned home, where he was, as before, carefully watched.

His next escapade was the result of an accident. B. and his father were at a neighbour's one evening, and while paring apples, the old man accidentally cut his hand so severely as to cause the blood to flow profusely. B. was observed to become restless, nervous, pale, and to have undergone a peculiar change in demeanour. Taking advantage of the distraction produced by the accident, B. escaped from the house and proceeded to a neighbouring farm-yard, where he cut the throat of a horse, killing it.

Recognizing the gravity of his offence, he escaped to the woods, where he remained in concealment until circumstances enabled him to commit another and still graver crime. Observing a young girl approaching the wood, he waited until she came near to his hiding-place, when he rushed out, seized her, and committed a criminal assault on her; for this last crime he was condemned to be hanged, but the sentence was commuted to imprisonment for life. While serving sentence he was again transferred to the prison-asylum. After serving about ten years of his sentence he was pardoned; *why* he was pardoned remains a mystery. On his way home from prison, and when within a short distance of his father's house, he went into a pasture, caught a horse, tied it to a telegraph pole, and mutilated it in a shocking manner, cutting a terrible gash in its neck, another in its abdomen, and a piece off the end of its tongue. For this act of atrocity he was tried, and though there was no doubt of his guilt, he was acquitted on the ground of insanity, and by warrant of the Lieutenant-Governor transferred to the Kingston Asylum. He was received at the asylum on the 29th Sept., 1879, and placed under careful supervision.

On the 19th August, 1884, he made his escape while attending a patients' pic-nic. He had only been absent from the asylum about an

hour, and while almost in sight of pursuing attendants, overtook a young girl whom he attempted to outrage. Her cries, however, brought help, and his designs were frustrated. For this offence he was handed over to the civil authorities, tried, convicted, and sentenced to six months in gaol. He is now serving out this sentence, and on its expiration will, no doubt, be released—to commit it is to be feared, more crimes.

Dr. Clarke, the assistant medical officer at the Kingston Asylum, writes to me that the trial seems to have been conducted in a very remarkable manner, and that the question of the prisoner's sanity or insanity was not gone into. "Poor B. was brought in 'guilty,' and the judge sentenced him to *six months' hard labour in gaol*, stating that he must be *lenient under the circumstances*. What the *circumstances* were, the asylum authorities have not yet discovered, but we may expect very interesting developments at the end of six months. We should not blame a foreigner if he asked the question, 'You have a Criminal Asylum—why do you *punish* criminals who are insane?'"

His grave offences have been enumerated in the preceding statement, but besides these, B. was guilty of very many minor offences, both while at home and while in the prison and asylum. While in the Criminal Asylum he attempted to castrate a poor imbecile inmate with an old shoe knife, which he had obtained in some unknown way. Another helpless imbecile he punctured in the abdomen with a table-fork until the omentum protruded; not satisfied with this, he bit the poor fellow, who had not even sense enough to cry out, in many places over the abdomen and chest.

He killed many small animals and birds, such as dogs, cats, doves, fowls, &c. He taught many innocent patients to masturbate, and introduced even more vicious habits.

He is a great coward, and was never known to attack any person or thing that would be likely to offer resistance.

Young girls, children, helpless lunatics, animals and birds, were selected for his operations.

The very sight of blood as we have seen, had a strange effect on this man, and worked a wonderful transformation. His countenance assumed a pallid hue, he became nervous and restless, and unless he was where he could be watched, he, so he stated, lost control of himself, and indulged in the proclivities for which he was notorious.

If so situated that he could not indulge his evil propensities, he was a quiet and useful man, but he could never be trusted. He had a fair education, and enjoyed reading newspapers, letters, etc., sent to him.

It is very doubtful if he entertained much affection for anyone. He seemed to like his stepmother better than anyone else, but even she, who had been a mother to him since early boyhood, he, according to his own confession, planned to outrage.

Commentary.—I would point out the great interest of this

case over and above the moral insanity or congenital defect of the moral sense under which this man labours, in regard to the influence of blood upon him. There can be no doubt that with some individuals it constitutes a fascination. If it be allowable to add to our psychological terms, we might speak of a *mania sanguinis*. Dr. Savage admitted a man from France into Bethlem Hospital some time ago, in a state of acute mania, one of whose earliest symptoms of insanity was the thirst for blood, which he endeavoured to satisfy by going to an abattoir in Paris. The man whose case I have brought forward had the same passion for gloating over blood, but had no attack of acute mania. The sight of blood when he cut the horse's throat was distinctly a delight to him, and at any time blood aroused in him the worst elements of his nature. Instances will easily be recalled in which murderers, undoubtedly insane, have described the intense pleasure they experienced in the warm blood of children. Is it not a more scientific proceeding to recognise and study this taste for blood than to deny its existence as a moral insanity?

In reference to moral imbeciles, I would cite the opinion of Dr. Kerlin, because his views as to educating them are very striking and important, coming as they do from the head of an institution for idiots. He says, in his last Annual Report:—"It is a mournful conclusion that has been reached after twenty-five years of experience, that in every institution of this kind, and probably to a far greater extent in our refuges and charity schools, there exists a class of children to whom the offices of a school-room should not be applied; these are the so-called moral idiots, or juvenile insane, who are often precocious in their ability to receive instruction, but whose moral infirmity is radical and incurable. The early detection of these cases is not difficult; they should be subjects for life-long detention; their existence can be made happy and useful, and they will train into comparative docility and harmlessness if kept under a uniform, temperate, and positive restriction. The school-room fosters the ill we would cure; in teaching them to write we give them an illimitable power of mischief—in educating them at all, except to physical work, we are adding to their armament of deception and misdemeanour."

I received only within the last few days a letter from Mr. Millard, the late superintendent of the Eastern Counties Asylum for Idiots at Colchester, in which he writes—"I have often had cases of moral imbecility under my care which re-

quire special attention. I know a respectable young man now in Ipswich gaol, for the third time, who is morally insane."

The practical question which presents itself is that of punishment. If we could but free ourselves for a moment from the legal questions connected with such a case as that I have narrated, we should surely be more able to study it from a purely pathological standpoint. We are still, it seems to me, if I might use a theological term, under the curse of the law. Is it not, then, true that men are born with organizations which prompt them to the commission of acts like those committed by this unfortunate man, and that the lower instincts are in abnormal force, or the controlling power is weak? Such a man as this is a reversion to an old savage type, and is born by accident in the wrong century. He would have had sufficient scope for his bloodthirsty propensities, and been in harmony with his environment, in a barbaric age, or at the present day in certain parts of Africa, but he cannot be tolerated now as a member of civilized society. But what is to be done with the man who, from no fault of his own, is born in the 19th instead of a long-past century? Are we to punish him for his involuntary anachronism? It is scarcely possible to conceive a more delicate question for medical or legal adjudication than whether the man who commits a crime is an example of vice, or whether he has so far passed beyond the influence of deterrent motives that he is morally irresponsible for the act. Can deterrent motives cease to be efficacious in any mind in which reason remains intact? Let us see how the pure psychologist, not the mental physician, regards this question from his point of view. Take for instance Mr. Bain. After referring to weakness of intellect and to delusions as causes of inability to recognise the consequences of actions, he has no metaphysical difficulty in admitting that in moral insanity there exists a mental condition in which, while the subject is not beyond the influence of motives of prospective pain or pleasure, he has so furious an impulse towards crime, that the greatest array of motives which can be brought to bear upon him is insufficient to prevent its commission. "If," he observes, "the organism were somewhat less, the motives might be sufficient; they have their weight, but are overpowered by a mightier force. . . . Any one who has not to deal with a whole community, but with separate individuals, apart and out of sight, does make allowance for moral inability and

inequality of moral attainment. . . . The public administration is hampered by general rules, and is therefore unable to make the same degree of allowance." Bain contrasts the case of the school-boy whose anger has led him to injure another boy, with the subject of moral insanity. In the former case it is right because it is possible to supply through punishment another motive which will counteract the repetition of the act, but in the latter case, where there are impulses morbidly strong which can only in a very limited degree be counterworked by the apprehension of consequences, Bain allows that the application of a stronger motive falls through, and that punishment is no longer the legitimate remedy. It is as cruel as it is useless. We must, however, make it impossible for him to indulge his deplorable propensities, and in some instances, perhaps, moral influences may modify the tendencies of even this class of beings, Opinions will differ, I think, as to whether it is wise to deprive them of the advantages of education, as proposed by Dr. Kerlin.

Cases Contributed by Dr. PERCY SMITH, Assistant Medical Officer, Bethlem Hospital.

I.—*Two Cases of Moral Insanity.*

CASE I.—B., æt. 53, son of a highly-respected and well-to-do city merchant. One paternal uncle was insane for a short time after business losses; another uncle married a servant, and among his children was a "ne'er-do-well." Other members of the family have decided musical and artistic genius.

Patient was the youngest of eight children. His mother died of cholera shortly after his birth, so that he had not the advantage of her training in youth. His father was a very strictly religious man, with rather narrow views, and very little tolerance of other people's opinions, and was strong-willed, fond of having his wishes and orders strictly carried out.

While the patient was a boy he was always mischievous, and though possessing a good memory, and quickness and aptitude for learning if he took trouble, he would never settle to work. In youth, he was sent to live with a clergyman, with a view to his entering the Church; but as he did not display the requisite frame of mind for that profession, he was taken into his father's business. For some years he remained at work, but would never submit willingly to his superiors, and often took holidays without leave. This was, however, overlooked for a time. It was then discovered rather suddenly that he had

married a hairdresser's daughter much below him socially, without having provided a home for her. His indulgent father provided them with means to live, and finally, as he would not submit to his elder brothers in business, he was started on his own account. He, however, after a short time, neglected this, and was always at race meetings instead of at work. His business failed, his father paying his debts. About this time his wife died, leaving two children, a boy and a girl. As our patient was not in a position to provide for them, they were taken care of and clothed and educated at the expense of his father. For the last 15 years he has earned a precarious living, sometimes on his own account, sometimes in other people's employ, but neglects whatever he has to do in the same way as formerly. A few years ago he married again a person socially beneath him, and his habits have not brought his wife much happiness. Some money left him by his father he soon squandered, and he has been a constant source of anxiety to his brothers and sisters. He is now to be found drinking in public-houses when he should be working, but always seems light-hearted and jolly, as if he were utterly unable to appreciate the trouble he has caused other people. Pecuniary difficulties never seem to cause him the slightest anxiety, and he does not seem to have any desire to prepare for old age.

This case might be looked upon, and, in fact, is looked upon, by his immediate relatives as one of simple wickedness, his intellect seeming to be perfectly sound. Those who take this view will probably admit that the history of his son points clearly to congenital moral imbecility in him, no doubt inherited directly from the unstable father.

CASE II.—B., jun., æt. 26, the son of Case I. When quite a child was very passionate and troublesome. He also early developed a malicious pleasure in playing practical jokes, such as pulling away a chair when anyone was about to sit down, pushing other children out of swings, &c. As his father habitually neglected him, and left him to the care of his grandfather and two very careful aunts, he was practically free from the influence of his father, who cannot, therefore, be blamed for his conduct.

He was sent to the Blue-coat School, but, after a stormy career there, had to be expelled. He was then sent to a situation in an office in the city. One day he was found to have bolted with some money belonging to his employers. He was caught, and his offence hushed up out of respect for his grandfather. He was then sent to sea. After two or three voyages he got tired of that, and left his ship. As he was now upon his own resources, he was hard pressed to know how to live. He took, however, perhaps the wisest course under the circumstances, and enlisted as a private in a line regiment. When last heard of he had been in the Zulu War, at the battle of Ulundi. It is

to be hoped that the discipline of the Army may keep him out of mischief. He will probably, however, desert sooner or later.

In both cases the defect appears to consist in a want of appreciation of the results of actions and inability to reform after repeated disasters have been brought about by the misguided will. In both cases the patient has, after a great fall, always promised to amend his ways; but, like the dipsomaniac, has never been able to resist the temptation to temporary pleasure, regardless of consequences.

II.—*Cases of Temporary Improvement of Mental Symptoms co-existent with the Development of Local Inflammations, with relapse upon the diminution and cure of the latter.*

The two following cases exhibit what is very commonly seen in asylums, viz., the temporary abeyance of mental symptoms concurrently with the establishment of some local inflammation. They are recorded because the particular local diseases observed are of somewhat rare occurrence, at least in lunacy practice.

CASE I.—*Initial Excitement—Injury to Head—Orbital Cellulitis—Melancholia.*

J. M., a clerk, aged 30, single. Admitted into Bethlem Hospital June 19, 1885. No insane inheritance. Father died of some lung disease. One previous attack of insanity six years ago, for which he was confined in Haywards Heath Asylum. Present attack began four days ago; became noisy and violent, attempting to injure himself; was taken to Guy's Hospital, as he was considered by a doctor to be suffering from meningitis. When in the hospital he was constantly shouting, quacking like a duck, and running about the ward in his night-shirt. He was violent to nurses and other patients, and butted at a window with his head, cutting his forehead. Directly after this he was removed to Bethlem Hospital, and on admission was pale, apathetic and dull, and would not answer questions. He was put to bed at once. His tongue was dry and furred; there was no bleeding from nose or ears, but there were some small superficial cuts on the left side of the forehead, slight bruising of the left cheek, and swelling of the left ear, and some small, sharp-margined hemorrhages in the left conjunctiva. The next day he was still dull and apathetic; the left conjunctiva was congested, and there was some chemosis and swelling of lids and thin blood-stained discharge. The left pupil was larger than right, but acted to light. On June 21 the eyeball was prominent, and there was more chemosis. The cornea remained clear.

June 22.—Mentally dull and apathetic; occasionally complains of

his eye; no headache, vomiting or convulsion. Temp. 98; ophthalmoscopically nothing abnormal discovered.

June 25.—Slight swelling of left optic disc; eyeball more prominent; hardness and deep fluctuation below eye in lower inner angle of orbit. Temp. 98°; makes no complaint, and is still apathetic.

June 26.—Under chloroform an incision was made by Mr. J. B. Lawford, of St. Thomas's Hospital, along the lower margin of the orbit, and a considerable quantity of pus evacuated. Still drowsy, but not so much as on admission.

July 1.—Mentally seems much brighter; will converse; says he feels very much better. Takes food well, sleeps well. Does not appear to have any delusions.

July 8.—Eye doing well; ophthalmoscopically normal.

July 18.—Wound almost healed, only a small sinus remaining. For the last 10 days has been fairly cheerful, but last night was somewhat excited.

Aug. 1.—Has now passed into a condition of profound depression; sits alone, will not answer questions, refuses food; hands blue and cold, pulse feeble. Wound healed, except for a very slight superficial discharge.

In this case the patient on admission was suffering from the effects of injury to his head, the symptoms of concussion replacing quickly the excitement he had at first displayed. With the full development of orbital cellulitis, his mental condition improved to a very considerable extent, but only to pass into profound depression concurrently with the healing of the abscess.

CASE II.—*Melancholia—Punctured Wound of Larynx—Abscess of Larynx (?)*.

C. B., æt. 57. Admitted into Bethlem Hospital July 18, 1885; no insane inheritance. For a month before admission, after some business trouble, he had been depressed, restless, unable to sleep, thought he was "damned," and became suspicious that he was followed. Five days before admission he stabbed his throat with the point of a knife.

On admission there was a recently-healed incision, about $1\frac{1}{2}$ inch long, over the lower border of the thyroid cartilage. The scar was not adherent to the subjacent structures. There was no dyspnoea or dysphagia, but the voice was reduced to a mere whisper. On laryngoscopic examination, there was seen to be general congestion of the lining membrane of the larynx, the left vocal cord being hidden (except at its extreme posterior end) by a prominent swelling projecting from under the epiglottis. The swelling was round in shape, bright-red in most of its extent, but yellow on the upper surface, and rendered the left vocal cord immovable. From the wife it was learned

that there was no alteration in his voice immediately after the stab, but that on the day of admission his voice became at first hoarse and then a whisper.

Mentally he was only slightly depressed, acknowledged that he had had some foolish ideas, but said that he had now got rid of them all, and felt fairly well.

July 27.—Both vocal cords seen, and both move freely. Inflammatory swelling reduced to a slight prominence; still with a white upper surface. Has not coughed up any pus. Voice almost natural. More cheerful.

Aug. 4.—Voice natural; has now relapsed into profound depression. Thinks he is lost; cries occasionally, and is always reading the Bible or hymns. Will not allow laryngoscopic examination.

It was not thought advisable to pass a laryngeal lancet down the throat, as the patient was suicidal; and as there was no dyspnoea, the case was simply watched. This line of treatment was justified by the steady diminution of the inflammatory swelling. No pus was ever seen to be welling out of the swelling, but there was always a yellowish-white spot at the most prominent part, as if pus were there.

III.—*Case of Hysteria in a Boy.*

Dr. Savage, in the last number of the "Journal of Mental Science," recorded a case of marked hysteria in a boy who was a patient in Bethlem Hospital. The following case appears to come under the same head.

A. W., *æt.* 12, a boy at King Edward's School, Witley, recently admitted to the school, was first seen by me on July 6. The history was that the day before, when in the playground, he had apparently fainted, and had bad frontal headache. He was put to bed, and then could neither swallow nor speak. When I saw him he was in bed, looked somewhat anæmic, protruded his tongue when asked, but when questioned as to his illness, he seemed unable to speak, though he opened his mouth, and put his hand to his forehead. He was able to swallow liquid. His heart and lungs were normal, and temperature 98° F. The left pupil seemed slightly larger than the right. There was no vomiting or convulsion, and no evidence of any ear disease. As the diagnosis lay between malingering, hysteria, or grave cerebral disease, he was watched for a few days, and kept on milk diet. It was found that his power of swallowing gradually returned, and he occasionally asked for food when very hungry. He still pointed to his head when asked what was the matter. He was then allowed to go in the playground, and against malingering it was noticed that when with other boys he still seemed unable to speak, and they made fun of him in consequence.

Finally his speech came back completely, according to his own account, after coughing and spitting up some blood. The infirmary attendant, however, knew nothing of this. He is now quite well.

He states that four years ago he had a similar attack, with inability to speak or swallow, and says the difficulty in swallowing was caused by something rising in his throat.

Two Cases of Thrombosis of Cerebral Sinuses. By JOSEPH WIGLESWORTH, M.D. Lond., Assistant Medical Officer, Rainhill Asylum.

CASE I.—Susan D., æt. 33, single, was admitted into Rainhill Asylum on Dec. 13th, 1884.

History.—The family history did not disclose any hereditary taint, except that an aunt had suffered from epilepsy. Patient had managed a public-house, but was said always to have been steady and temperate. Her illness commenced a fortnight before admission, and was considered to have been due to mental distress, occasioned by the fact that she had got wrong in her accounts, in explanation of which circumstance she stated that goods had been stolen from her. She became very quiet and dull, sitting still without speaking, and nothing could be got out of her in reply to questions; occasionally however, she would jump up suddenly and scream a little.

State on Admission.—On admission she was noted to be a short, poorly-nourished woman, looking older than her stated age. Her viscera appeared sound. She was very restless and excited on the night of admission, and had to be put to sleep in a side-room, but she was out of bed all night, and in the morning was quite naked, and her room was very dirty. On this morning (14th) she could not be got to answer any questions, but preserved an obstinate silence; she resisted strongly all attempts to examine her, burying her head in the pillow, and keeping her arms very rigid. She was, however, more sensible than appeared at first sight, and after a time became a little more communicative, answering a few questions, but in an irrational manner. She was out of bed and very noisy all the following night, and very restless all the next day, wandering about aimlessly. She at times muttered a few words, but nothing that she said could be made out. On the morning of the 17th she was reported to have slept somewhat better during the two previous nights; she continued restless, however, during the daytime, lying or rolling on the floor; she resisted being dressed and undressed, and had to be fed with her food. Though keeping silence, she appeared to understand something of what was said to her, for being asked how she was, said "better," but this was about all that could be got out of her. She gradually became more dull, and on the 20th could not be got to answer a single question; she sat in a chair with her head thrown back, and kept food for a

long time in her mouth before swallowing it, and when her arms were raised in the air, they were retained for a short time in the position in which they were placed. On the morning of the 22nd she was looking pinched and ill, and her pulse being very feeble, she was put to bed; signs of pneumonia of the left base soon developed themselves, and she rapidly became more prostrate. She then lapsed into a very morose condition, resisting everything that was done for her, and making frequently a sort of screaming noise as if in pain, which was very distressing to hear; passed her evacuations in bed, and took very little food. She died on the afternoon of the 25th (12 days after admission, and 26 days from the reported commencement of her illness)

Autopsy.—Dec. 26th (23 hours after death.)

Cranium.—Skull-cap dense. Dura-mater very adherent. Slight excess of fluid in subdural space. Cerebral sinuses, longitudinal and lateral, filled with tolerably firm ante-mortem clot, which was in some parts decolourised, and everywhere adherent to the walls of the sinuses; the clots extended into the jugular foramina, but their further course could not be traced; at these spots the clots were commencing to break down in the centre, but this condition was not apparent in the longitudinal sinus; the main veins ramifying on the surface of the cerebrum, and emptying into the longitudinal sinus, were likewise, for the most part, firmly plugged with thrombi. The middle ear on each side was healthy, and there was no evidence of any local bone or other disease within the cranium. Arachnoid and pia-mater much injected; these membranes not thickened, and stripped readily—no adhesions. Slight excess of subarachnoid fluid. Pink staining of surface of gyri. Slight wasting of gyri in frontal regions, and at upper part of fissures of Rolando, there being a distinct depression here, on each side. Cortex of normal depth, but of dark colour—striation indistinct. Puncta cruenta numerous. Consistence of brain fairly good. Ventricles not distinctly dilated. Basal ganglia normal. Cerebellum, pons and medulla normal. Basal vessels healthy.

Brain = 1307 grammes.

Right hemisphere = 550 grammes (partly stripped.)

Left " = 568 " (unstripped.)

Cerebellum = 148 "

Pons = 15 "

Medulla oblongata = 7 "

1288 "

The lower half of the lower lobe of the left lung was solidified, but there was nothing else particularly worthy of note in either the thoracic or abdominal viscera.

CASE II.—Jane L., æt. 57, had been an inmate of Rainhill Asylum for 32 years; she was the subject of chronic mania with dementia. For three weeks before her death she had suffered from diarrhœa together

with bronchitis, which latter developing into a broncho-pneumonia, appeared to be the immediate cause of her decease, which took place on May 9th, 1883; two days before her death an inflammatory swelling of the left parotid region set in. No alteration was noticed in her mental symptoms during her fatal illness, as compared with the conditions which had existed for many years previously.

Autopsy (24 hours after death).

Cranium.—Skull-cap soft and thick; dura-mater somewhat abnormally adherent; on inner surface of dura-mater a very thin, gelatinous red lamina, which could be stripped off intact. Longitudinal sinus filled throughout its whole length with an organised thrombus of some standing; this was fibrinous, decolourised, obscurely laminated, adherent to lining wall of sinus, and somewhat friable in places; it stretched also along the lateral sinuses, reaching the jugular foramen on the left side but not on the right, and did not here fill the whole area of the vessels; the thrombus reached into the petrosal sinuses, and was also present in the large veins ramifying on the cortex, and emptying into the longitudinal sinus. Arachnoid opaque; it and pia-mater thickened; stripped with facility. Large excess of subarachnoid fluid. The surface of the cortex of the left postero-parietal lobule was occupied with a circular patch of punctiform hæmorrhages, the margins of the patch being sharply defined by a ring of these; a similar but smaller patch existed on the cortex in the centre of the posterior central gyrus. On section it was found that these punctiform hæmorrhages extended through the cortex into the white matter for a short distance. Cortex elsewhere pale, slightly thinned, and striation indistinct. Brain generally somewhat wet, but of fair consistence. Ventricles slightly dilated.

Brain = 1057 grammes.

Right hemisphere = 404 grammes } both stripped.

Left " = 409 "

Cerebellum = 141 "

Pons = 18.5 "

Medulla oblongata = 8 "

980.5

No local bone or other mischief (beyond that described) within the cranium.

Left lung cirrhotic, being seamed throughout with fibrous bands. *Right lung* exhibited in its lower lobe numerous scattered solidified patches. The *heart* and *abdominal viscera* presented nothing particularly noteworthy.

The *left parotid gland* was found on section infiltrated with pus, and a small vein running through it was occupied by a thrombus, but the internal jugular vein was perfectly normal, so that so far as the affection of the gland might have had any connection with that of the cerebral sinuses, it partook of the nature of a secondary—metastatic—process.

Remarks.—As is well known, cases of thrombosis of the cerebral sinuses may be divided broadly into two classes—one in which the affection of the sinuses is of local origin, and due to such causes as caries of bone—most frequently of the petrous portion of the temporal; the other, in which the cause has to be sought for in some general, constitutional state, such as may favour the formation of thrombi, in other venous systems. The former class of cases—the more numerous of the two—does not here concern us, both the cases reported above coming under the latter category. In the second of these two cases a cause for the blood stasis, and subsequent clotting, may perhaps be found in the general inactivity and debility of the patient, which would have favoured a diminution in the rate of the blood-flow (always conducted as it is in these regions at a mechanical disadvantage), accentuated as this slowing of the current would undoubtedly have been by the chronic pulmonary mischief (cirrhotic lung) tending to engorgement of the right side of the heart. The case, indeed, presents no special features of interest, occurring, as it did, in an old and chronic dement, and not impressing any notable change upon the mental symptoms. It is otherwise, however, with the first of the cases recorded. Here we have a recent and acute case of insanity running a rapid course to a fatal termination, the whole duration of the case (if the history could be trusted—and there was no reason to doubt it) not having been more than 26 days. That the clotting of the blood in the vessels was the first link in the chain of events, it may not be possible to assert absolutely; but in my opinion it was both the direct cause of the patient's insanity and of her death, the pneumonia which was the immediate precursor of this being clearly of secondary origin. It is notoriously difficult to assign an exact limit to the age of an ante-mortem clot from appearances alone, but I see no reason why the one in question should not have existed, or have commenced its existence at the time of the onset of the patient's mental trouble. As to the causes, however, that led to the clotting of the blood in the sinuses in this case, it is not easy to form an opinion, and we are driven to the conjecture of some general blood-dyscrasia. It would be interesting to know whether, in cases of this nature occurring in adults, symptoms similar to those here recorded—especially the presence for a time of a semi-cataleptoid condition—have been before met with.

Brain-disease of Traumatic Origin: Cases. By WM. JULIUS MICKLE, M.D., M.R.C.P., Grove Hall Asylum, London.*

Between the clinical features of the following cases are found differences flowing from two sources—one, the situation of the more marked changes following the injury; the other, the habitudes, tendencies, spread of, and line of action pursued by the morbid intracranial process eventually existing and dependent upon the injury.

In the first of the two cases, given below, the resultant atrophy and degeneration were more marked in the left frontal lobe than anywhere else, and some cerebro-meningeal adhesions existed over the gyrus rectus and gyrus marginalis on both sides; over the lower part of the left anterior central gyrus, and over the left insula. The atrophy of left cerebral hemisphere somewhat diffuse but chiefly of the frontal lobe—the cerebro-meningeal adhesions, mainly of orbital and marginal surfaces, and the degeneration of the left insula, were accompanied by amnesia; also, and particularly after the convulsive attacks, by a condition approximating paraphasia and (in a less degree) word-deafness, but obscured and complicated by the co-existing dementia.

The above changes had followed traumatic localized meningitis and hæmorrhage, and pachymeningitic changes; and these were sequential to a severe and destructive cranio-cerebral injury. And the symptoms are to be connected with the position and extent of the resulting lesion, and the line of action taken by the processes of inflammation, resorption, and degeneration, following that lesion. In this regard it is to be compared with the next case, with which it has close pathological links. In both cases there had been considerable chronic meningitis and more or less of resulting adhesion; to say nothing of the pachymeningitis, more marked in the first than in the second case.

This first one, therefore, quite falls into the group of cases where a form of aphasia depends upon diffuse textural change, more marked in the grey cortex of the left frontal lobe than elsewhere. Viewing the subject in its broad aspects, several examples of this group were given in detail in one part of a paper on some of the varieties of aphasia published by the present writer in the American "*Alienist and Neurologist*" for April, 1882. It is unnecessary to

* Read at the Annual Meeting of the British Medical Association, Cardiff.

recapitulate here the commentary made, and the condensed summary given in that paper as to the symptoms and lesions in cases belonging to this group. But it may be briefly noted that patients of this group retain but little gesture-language; display considerable impairment of memory and general dementia; only in a momentary and imperfect manner show any lively and appropriate emotion in response to external impressions and influences; at times utter broken words and phrases, oaths, or foul expressions; and if subject to recurring epileptiform seizures are subject, also, thereafter, to a temporary abolition of speech, or to a grave increase or modification of any already existing affection of articulate language.

In the second case, as in the first, there was some cerebral atrophy, and this, as usual, mainly or solely of the frontoparietal lobes. The adhesion and decortication were principally about the base and mesial surfaces of the brain; portions of the orbital gyri, of the marginal gyri on the mesial aspect, and of the uncinate gyri, being the parts chiefly adherent to the meninges, and the traces of adhesive traumatic meningitis about the base being very decided.

Here, then, following the intracranial inflammatory effects of a severe cephalic injury were traces of chronic meningitis, with some atrophy of brain, and compensatory increase of serosity. The cerebrum also was involved in the original morbid process; so were the optic nerves, with gradual failure of sight.

The depressed form of emotional disturbance was unusually well-marked in this case, which is one of those forming, patho-histologically, a transition between the most typical lesion of general paralysis on the one hand, and localized chronic meningitis on the other; but congenerous rather with the former. The pathological changes, however, had soon become "diffuse." They began rather at the base, where the effects of the original injury had fallen with greatest severity, and their course may have relation to the course of the symptoms.

In this latter case, as compared with the former, the morbid process set up by injury was of a more diffuse character, spreading and extending more widely, and leading eventually to slightly indurative changes not very circumscribed or limited in extent.

The present is merely complementary to other papers on brain-disease following cephalic traumatism, published by me in the "*Journal of Mental Science*" for April, 1881, and

for January, 1883, and in the "Medical Press and Circular" of January 10th, 1883. To these the reader is referred for the discussion of various points, which need not be repeated here.

CASE I.—H. W., aged 57, married, a labourer, weight 122 lbs., admitted September 1, 1883, died January 1, 1884, the mental disease for which he was admitted being stated to be the first attack, to be then of ten days' duration, and attributed to convulsive "fits." The certificate spoke (*inter alia*) of the patient's false idea that some one was under his bed, of his disinclination to answer questions, and his irrelevancy of language, and of his occasional violence of demeanour and threats to murder his wife.

It appeared that some years previously the patient sustained by accident a severe injury to the head, causing a compound comminuted fracture of the skull with subsequent loss of bone. For the fracture he had been treated in one of the London hospitals. Subsequently to this he had never been so well or capable mentally; convulsions had supervened latterly, and his mental powers had continually retrograded, but not extremely so until after a "fit" occurring ten days prior to his admission. The evidence of this severe cranial injury existed in the form of a deep depression in the skull over the course of the sagittal suture and about two inches in front of the junction of this suture with the lambdoidal. This depression was of considerable depth and capacity. There was also a scar on the vertex in front of the indentation and slightly to the left of the sagittal suture. A scar showed on the left cheek, and a blue scar on the left orbital margin.

The complexion was fresh and rosy, the skin clear, hair greyish, head large and partially bald. The patient was edentulous, except in part of the right side of the lower jaw, in consequence of which the tongue was protruded somewhat to the left, and the mouth distorted. Pupils equal, slightly irregular, rather sluggish to light only. Except for some râles, friction, and dulness of right lung, the viscera appeared to be fairly healthy; and no evidences of constitutional syphilis were found.

Several convulsive attacks occurred on the days following admission, and the patient was placed in bed. Here at times convulsive twitches played about the right upper limb, and on a few occasions convulsions, mainly tonic, affected that limb principally and the two lower limbs in less degree, the arm being rigidly thrown upwards and outwards. After the convulsions the right limbs were palsied, and the knee-jerk was defective in both legs.

When admitted, and before any convulsions occurred here, his replies were irrelevant and incoherent. A few days later there appeared to be some paraphasia and perhaps word-deafness complicating the dementia. Q.—"What is your name?" A.—"Well, I'll" (then began restlessly pulling the right hand with the left).

Q.—“What is your name?” A.—“That do.” Q.—“Where do you live?” A.—“This do” (looking at his hand). In fact it was difficult to keep his attention, or get a reply, and the replies to the simplest questions were irrelevant and fragmentary, and usually unintelligible as regards the communication of any idea to his mind. Not only so, but he understood but little of what was said to him, and that only the most simple propositions. The words addressed to him often seemed to fail to arouse the appropriate idea, and when attempting a reply those used by him were usually inappropriate and devoid of relevancy.

By the end of about a month the condition of speech had much improved. Though stupid about obeying directions, and readily misapprehending requests made, and directions given to him, he could now answer simple questions in a hesitating, broken, faltering manner; mumbling, repeating phrases, and showing considerable amnesia. Some of his replies were relevant but inaccurate, a few were both inaccrurate and irrelevant. On standing he readily became shaky, tremulous.

About a month still later he was found one morning to be stupid and unable to speak. After the action of a laxative enema he was able to speak, but what he said was irrelevant and often unintelligible. Q.—“What is your name?” A.—“Um die”—or—“Jess.” The mouth was somewhat drawn to the left, the right arm was paretic, the right leg less so.—From this state he soon recovered.

About three weeks before death he was taken ill rapidly. Temp. 100°, pulse 116, respiration 38, and the inspiration made in three or four spasmodic efforts, bronchial râles, some dulness and crepitation, diarrhoea, occasional vomiting, dry brown furred tongue. He improved, then died rather rapidly.

Necropsy, in abstract.—Over the sagittal suture and somewhat to its left, and extending two inches from the occipital bone, was a hole in the skull, of about the size of a silver florin piece, closed by adherent scalp, and, partially, by a fibrous membrane. Pachymeningitic changes, consisting of old thickening of dura mater, especially on the left side, and of soft, adherent but separable, hæmorrhagic, membraniform, vascular and ecchymosed formations on the left side of dura at vertex, and extending to the left anterior and middle fossæ of skull-base, and to the tentorium; while the same existed in the right middle fossa also.

Some patches of white fibroid thickening in the arteries at the base of the brain.

Old ordinary meningeal opacity, etc., of the usual distribution. Some cerebral atrophy of the fronto-parietal lobes, more marked in the left hemisphere, and particularly in its frontal lobe, the left hemisphere weighing only 18½ oz., the right weighing 20 oz.

Some cerebro-meningeal adhesions over the gyri recti and adjacent portions of the gyri marginales, and by the medium of these marginal

gyri the two hemispheres cohered: adhesions also over the lower inch of the surface of the left anterior central gyrus and at lateral walls of the Sylvian fissure. The grey of the left insula slightly adherent to the meninges, and atrophied; also softer and more readily separating into layers than that of the right. The left orbital grey more atrophied than the right. The olfactory bulbs not much affected. Rusty staining of meninges over the inferior surface of the temporo-sphenoidal lobes.

The brain, generally, was of fair consistence.

The ependyma of the lateral ventricles, and of the fourth ventricle, was thickened and granulated.

Pons Varolii and medulla oblongata 1 oz., cerebellum 5 oz. Fluid and blood from cranial cavity 4 fl. oz.

The præcentral sulcus, especially on the right side, ran into the Sylvian fissure, and the perpendicular ramus of the latter was very short. Both parietal fissures ran into the transverse occipital except for a small gyral fold posteriorly. The occipital lobes were extremely unsymmetrical in shape, a notch on the inner side of right tip being opposed by a boss on the left.

Heart flabby, 13 oz. Some slight thickening of mitral and aortic valves. Aorta extremely atheromatous and calcareous, and in parts abraded. Coronary arteries somewhat atheromatous.

Some old scattered pleuritic adhesions in the right side of chest. Some old indurated fibroid knots about the back of right lung. In the upper lobe of left lung was a small collection of thick creamy laudable pus, the lower lobe was congested.

The kidneys were congenitally lobulate, they were slightly indurated. There was a subcapsular abscess at the summit of the left kidney, with a circumrenal abscess, and the left adrenal was apparently disorganized; peritoneum hereabouts deeply congested. Spleen firm. Curvature of spine above diaphragm. Left lung 18 oz., right 20½ oz., spleen 4½ oz., right kidney 6 oz., left 5½ oz., liver 63 oz.

CASE II.—J. W. T., aged 47, married, a timekeeper, admitted October 30, and died November 18, 1883. First attack of mental disease, worse for three weeks before admission.

It appeared that the patient had sustained a very severe blow on the head by a stone in December, 1881, and therefore nearly two years previous to his admission. He was never quite himself after this. To quote from the account given of the case by the patient's wife: "Until then"—the date of the injury—"he always enjoyed good health. The place struck was in front and slightly above the left ear. The doctor said the pad of muscle there saved his life; as it was, the injury caused a slight concussion, and he was confined to his bed for three weeks, after which he seemed fairly well until the June following, when he caught a slight cold which turned to inflammation of the lungs and he was very ill for several weeks. He then [later on] attended the Brompton Hospital, and derived great

benefit. In the following October [1882] his eyesight began to fail, his memory also; he got very nervous and restless at night, and low-spirited, and for the last three or four months he became subject to illusions [delusions] of all kinds, more particularly about money. He used to think many of the illusions were dreams. Another symptom was that he had such an increase of appetite. Previous to that he had always been a small eater; eating scarcely sufficient to keep up his strength."

The "certificate" and "statement," and persons bringing the patient to the asylum, asserted that the patient was suicidal and dangerous to others; incoherent in speech; of defective intelligence and impaired memory; that he could not tell the name of any ship he served in whilst in the Royal Navy; that he acted strangely, as, for example, in secreting trifling objects about the house and filling his pockets with coke; that he had the delusion that money had been left at his house for him; that he had been violent and unmanageable; had broken windows; had put a knife beneath his pillow; and had threatened "to kill soldiers." Also, that he had for some time been strange in manner and low in spirits.

On admission, he was placed in bed, being thin, feeble, blind or nearly so, with difficulty induced to take his food, and having a few râles in the right lung. The face was sallow and parchment-like. The pupils were dilated, slightly irregular in outline, sluggish to light, somewhat so in movements as of accommodation, and acting defectively to painful sensory cutaneous impressions; the left was slightly the larger. The forehead was corrugated and raised. Speech much impaired, mumbling, low and slow; when he was up speech was accompanied with slight labial and facial twitches, and was stumbling, stopping, and shaking; becoming mumbling, and at times unintelligible. Tongue tremulous, dry and reddish along its middle. Trembling was readily induced, and when he was standing up tremor soon invaded the whole frame. Fluids only were swallowed, there was often difficulty in inducing him to take even these, and latterly peptonized enemata were used. The gait was shaky and unsafe, partly, perhaps, owing to defective sight. He could, however, walk a few steps, but not further. Urine non-albuminous. Pulse much affected by position.

He was depressed, readily weeping; in explaining matters gave a rambling, incoherent account, or even a fragmentary and unintelligible one. He could not tell where he had been living recently, or at what working. Though laid up in bed, he said he had been all over the place to-day. He was dull and slow to understand any instruction he received, but when once started would protrude the tongue or grip with the hand as directed. He was of wet and dirty habits.

He continued to be feeble, depressed; whining, moaning, and readily weeping, timid, emotionally disturbed and distressed by trifles,

even by being moved, fed, cleaned, or merely touched. He still swallowed badly.

Pneumonia set in, and became marked, especially in the right lung; with vomiting, refusal of food, and increased dysphagia; and death soon closed the scene.

Necropsy, in abstract, twenty-eight hours after death.—Brownish discoloration of skin. Dura slightly thickened. Considerable amount of fluid in arachnoid and subarachnoid spaces. Slight thickening of arteries at base of brain, especially of left middle cerebral.

The meningeal changes were highly marked, and slightly more so on the left side; particularly were they marked at the anterior base and about the optic nerves and interpeduncular space. Here the thickened arachnoid formed a firm bridging membrane, and strands of false membrane tied down the optic nerves and neighbouring parts. The arachnoid and pia were thick, opaque, milky, and cedematous over the anterior and middle parts of the cerebrum. In front, and at the base, were interlobar adhesions.

There were only slight adhesion and decortication—of the first frontal gyrus, gyrus rectus, orbital part of gyrus marginalis or pli de la zone externe, first, second, and third temporo-sphenoidal gyri, gyrus Hippocampi and its uncus on both sides. These changes, however, were more marked on the left orbital and unciform gyri than on the right. Slight cerebellar adhesions existed.

There was atrophy of the cerebral cortex in the fronto-parietal region, and especially in the orbital. Its grey was of a somewhat homogeneous appearance and faint slaty hue. Anteriorly the grey and white cerebral substances were firmish.

Slight thickening, induration and granulation of the lining membrane of the lateral and third ventricles; well-marked similar changes in that of the fourth ventricle. Velum tough.

Brain as removed with membranes, fluid, etc., 52 oz. Right cerebral hemisphere $20\frac{3}{8}$ oz, left 21 oz., cerebellum $5\frac{1}{8}$ oz., pons V. and med. obl. $\frac{3}{4}$ oz. Fluid and blood from cranial cavity $4\frac{1}{2}$ fl. oz.

Pneumonia; hypostatic, and more of right lung than of left. R. 43 oz., L. 31 oz. Somewhat big heart, $11\frac{3}{4}$ oz., slight coronary and aortic atheroma. Other viscera fairly healthy. Spleen firm, $4\frac{1}{2}$ oz. R. kidney $5\frac{1}{4}$ oz., two small ordinary cysts. L. kidney $5\frac{1}{2}$ oz.

OCCASIONAL NOTES OF THE QUARTER.

Proposed "Lunacy Districts (Scotland) Bill."

As the Bill which certain of the Parochial Boards in Scotland recently attempted to introduce into the House of Lords under the title of "Lunacy Districts (Scotland)" is a measure that deserves more consideration than it has received, and had it passed into law would have seriously affected the Chartered Asylums of Scotland, the following notes in regard to the history of this proposed Bill may not only be of interest, but also of use for reference in the future. We are indebted for them to Dr. Rorie, of the Royal Asylum, Dundee.

The Bill in its original form, namely, as it appeared in 1881, seems to have arisen out of a defect in the Prisons Act (Scotland) of 1877, as follows:—

In terms of the Act 20 and 21 Vic., cap. 71 (the Lunacy Act, Scotland, of 1857) under section 49 it was enacted that, with the view to the erection of asylums for the reception and care of pauper lunatics, and for the purposes of the said Act, Scotland should be divided into districts or divisions, as set forth in a schedule thereto annexed, and that the General Board of Commissioners in Lunacy should have the power, on the application of the Prison Board of any county interested, to alter or vary the said districts, either by combining counties or parts of counties, or dividing counties, or otherwise as they might think fit. In 1877, however, the Prisons Act (Scotland) was passed, one result of which was to put an end to Prison Boards, and although in this Prisons Act provision was made for the election of District Lunacy Boards, which previously had been chosen out of the Prison Boards, it was found that no legal authority existed having the power to make application for dividing, combining, or altering existing districts.

To meet this defect a Bill was brought before Parliament—"Lunacy Districts (Scotland), 1881"—which, as amended in Committee of House of Lords, and ordered to be printed 7th July, 1881, proposed that "the Lord Advocate shall have the power, on the application of the Commissioners of Supply of any county forming a lunacy district, or part of a lunacy district, to alter or vary the said districts, either by com-

bining counties or parts of counties, or dividing counties, or otherwise, as may be requisite.

Had this Bill passed, the result would have merely been that the power previously possessed by the Prison Boards, elected by Magistrates of Burghs and Commissioners of Supply, would have been conferred on the Commissioners of Supply. This Bill, however, was withdrawn.

In 1882 a new Lunacy Districts Bill (Scotland) was introduced into the House of Lords, and, as it first appeared, and was ordered to be printed 6th June, 1882, was to the following effect :—That “the General Board of Commissioners in Lunacy for Scotland shall have the power, on the application of the Commissioners of Supply of any county interested or the Magistrates of any Burgh interested, or the Parochial Board of any parish or combination interested, to alter or vary the said districts, either by combining counties or parts of counties, or dividing counties, or otherwise, as may be requisite; Provided always, that it shall be lawful to one of Her Majesty’s principal Secretaries of State, on a representation by such Commissioners of Supply, magistrates, or Parochial Board, to modify, alter, or confirm any decision pronounced by the Board on such application.” Here we have a serious departure from what was desired by the Bill of 1831. Had it been proposed that the General Board of Lunacy should have the power of dividing and altering lunacy districts on the application of the Magistrates of Burghs and Commissioners of Supply, little exception could have been taken to the measure, but to give this power of application to any Burgh, interested apart from the Commissioners of Supply, was the introduction of a clause apparently never originally contemplated, while the introduction of the parochial element into the Bill was little short of an infringement of the original Act of 1857, an Act specially framed for the transference of the management and control of the insane poor from Parochial Boards to an independent Board elected by the Commissioners of Supply and Magistrates of Burghs.

This Bill accordingly met with opposition, principally directed towards restricting the parochial powers, and in the Bill as amended and ordered to be printed 26th June, 1882, the power of petitioning, so far as the parishes were concerned, was confined to Parochial Boards having asylums of their own, the clause reading thus : “On the application of the Commissioners of Supply of any county interested, or the

Magistrates of any Burgh interested, or the Parochial Board of any parish or combination interested having an asylum of its own."

It was at once seen that the term "asylum of its own" was too vague and ambiguous to be satisfactory, and so in the amended Bill ordered by the House of Commons to be printed on 4th July, 1882, this clause was altered to "the Parochial Board of any parish or combination interested having a parochial asylum of its own, which it has erected or acquired with its own parochial funds prior to the passing of this Act," and further providing that "for the purposes of this Act the term 'parochial asylum' shall not include lunatic wards of poorhouses."

This Bill, however, was shortly afterwards withdrawn.

The Bill which, under the heading "Lunacy Districts (Scotland) Bill," it was recently sought to introduce into the House of Lords by the Parochial Boards was necessarily a purely parochial measure, and in its original shape would have amounted to little short of the repeal of the Act of 1857, the principal clause of the first draft of the Bill being as follows:—"Any parish or combination may, with the approval of one of Her Majesty's principal Secretaries of State, or the General Board of Commissioners in Lunacy for Scotland, elect to be a district under the said first-recited Act (1857): and thereupon such parish or combination shall be separated from the county or district of which it is a part, and be and become a separate district, and the Parochial Board of such parish or combination shall thereupon be and become the District Board of such district, and have all the powers of a District Board." It seems to have been felt, however, that such a Bill was too crude and revolutionary to have the slightest chance of becoming law. It was accordingly modified into the following:—

1. The General Board of Commissioners in Lunacy for Scotland (hereinafter called "The Board of Lunacy") shall have the power, on the application of the Commissioners of Supply of any county interested, or the Magistrates of any Burgh interested, or the Parochial Board of any parish or combination interested having a population of fifty thousand or upwards, or having one hundred pauper lunatics or upwards chargeable to such parish or combination, to alter or vary the said districts, either by combining counties or parts of counties, or dividing counties, or by combining parishes or otherwise, as they may think fit. Provided always, that

it shall be lawful to one of Her Majesty's principal Secretaries of State; on a representation by any Commissioners of Supply, or Magistrates, or Parochial Board interested, to modify, alter, annul, or confirm any decision pronounced by the Board of Lunacy on such application.

2. If one or more parishes shall, on the application of a Parochial Board, be constituted into a lunacy district under the provisions of this Act, the District Board in the case of a parish shall be the Parochial Board of such parish, and in the case of combined parishes the District Board shall consist of such number of representatives from each Parochial Board, not exceeding twenty in all, as may be fixed by the Board of Lunacy, having reference to the population of the parishes constituting such combination, such representatives to be elected annually by the Parochial Boards of those parishes; Provided always, that section fifty-nine of the first-recited Act shall not apply to any such lunacy district.

3. Where any Parochial Board has erected a parochial asylum prior to the passing of this Act fully adequate for the wants of such parish or combination the ratepayers of such parish or combination shall be exempt from any assessment for building or maintaining a district asylum.

Such is the Bill which it was sought to introduce, and the objections to it are obvious. In the first place it is contrary to the spirit of the Act of 1857, and in the second, in seeking to be freed from the operation of the 59th clause of that Act, Chartered Asylums, where pauper patients are received, would be left entirely at the mercy of the Parochial Boards.

By this clause District Lunacy Boards are bound to contract with Chartered Asylums to the extent of their available accommodation before erecting District Asylums, and this safeguard would have been completely destroyed under the proposed Bill. This effect the Lord Advocate, in replying to the parochial deputation, was careful to point out when he stated "that it was necessary to have regard to some matters not stated in the course of the interview. A Government must, of course, look at all sides of a question, and it was necessary to take care that any legislation upon this subject did not cause hardship or injustice to any existing bodies. Now there was one point he was sure they desired to keep in view. Take the case where there was already an asylum for a district. He was afraid, as the draft Bill stood, it might lead to the withdrawal of certain of the parishes which they

had provided for, and possibly leave the remainder of the district in possession of an asylum much too large for their wants."

Lunacy Legislation (England and Wales).

In the last number we stated that the Lunacy Bill of the late Government had been withdrawn. For a time it seemed possible that the new Government would be able to carry out their intention of pressing it forward, but ultimately the Bill was abandoned. A short Bill, however, was introduced and became law (48 and 49 Vict.), which had for its object the removal of a difficulty that had arisen in regard to the detention of lunatics, under certain circumstances, in workhouses. This Act, which consists of only four sections, has reference to Acts 16 and 17 Vict., c. 97, secs. 67, 68 (1853), and 25 and 26 Vict., c. 111, sec. 20 (1862). We give the sections entire:—

1.—This Act may be cited as the Lunacy Acts Amendment Act, 1885.

2.—Where, under the Lunatic Asylums Act, 1853, it shall be the duty of any relieving officer, overseer, or constable to give notice to or lay information before a justice as to any pauper who is or is deemed to be a lunatic, or as to any person wandering at large who is deemed to be a lunatic, or as to any other person deemed to be a lunatic who is not under proper care or control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, or to apprehend and take any such person wandering at large before a justice, and the relieving officer, overseer, or constable is satisfied that it is necessary for the public safety, or the welfare of the alleged lunatic, that before such notice or information can be given or laid, or the alleged lunatic can be brought before the justice, the alleged lunatic should be placed under care and control, the relieving officer, overseer, or constable may remove the alleged lunatic to the workhouse of the union in which the alleged lunatic is, and the master of the workhouse shall, unless there is no proper accommodation in the workhouse for the alleged lunatic, receive and relieve and detain him therein, but no person shall be so detained for more than *three days*; and before the expiration of that time the relieving officer, overseer, or constable shall give the notice to, or lay the information before the justice as to such alleged lunatic, or bring him before the justice, as the said Act requires.

3.—(a). In any case where, under section sixty-seven or section sixty-eight of the Lunatic Asylums Act, 1853, an order might be made for the removal of a lunatic to an asylum, hospital, or licensed

house, and the justice or justices shall be satisfied that it is expedient for the welfare of the lunatic or for the public safety that the lunatic should be forthwith placed under care and control, such justice or justices, if it shall appear to him or them that there is proper accommodation for such lunatic in the workhouse of the union in which the lunatic is, may make an order for taking the lunatic to and receiving him in the said workhouse.

(b.) An order under this section shall be deemed to authorise the detention of the lunatic for a period not exceeding *fourteen days* from its date; after which such detention shall not be lawful, except under the conditions mentioned in section twenty of the Lunacy Acts Amendment Act, 1862.

(c.) In any case where the justice or justices make an order for the removal of the lunatic to an asylum, hospital, or licensed house, an order under this section may also be made to provide for the detention of the lunatic until he can be removed as aforesaid; but such an order shall not be deemed to authorise the detention of the lunatic in the workhouse for more than *fourteen days*.

(d.) An order under this section may be made by any justice or justices of the peace having jurisdiction in the place where the lunatic is.

4.—This Act shall be construed as one with the Lunatic Asylums Act, 1853, and the Acts amending that Act, and expressions used in this Act shall according to the subject-matter in each case have the same meaning as in those Acts, save as in this Act otherwise provided.

In this Act "union" includes a parish for which there is a separate board of guardians.

This enactment will, it may be hoped, prove useful in the way intended, and put a stop to the disgraceful conflicts recently witnessed in our Police Courts between magistrates and workhouse officials, and commented upon in our last issue.

As the Government expressed its intention of bringing in a comprehensive Bill next Session (should it have the chance), the members of the Association would do well to be prepared for legislative changes, which may largely affect their interests for good or for evil. Indications were not wanting in the debate on the Lord Chancellor's Bill that the party then in opposition entertained those suspicions in regard to the motives and actions of mental specialists which find their natural development in very stringent lunacy laws. A just regard for the liberty of the subject, and an ample protection of those confined in asylums, ought not and will not be opposed by any fair medical psychologist, but a strenuous

endeavour will be required to insist upon the protection of physicians as well, whether these are employed to sign lunacy certificates, or are the superintendents of hospitals and asylums for the insane. This aspect of the subject was fully debated in the Psychology Section of the meeting of the British Medical Association held at Cardiff in July. A report of the discussion will be found in "Notes and News" of the present number.

Neave v. Hatherley.

"Jesuit-mania" may be added to the long list of varieties of insanity by those who desire to refine upon old-fashioned nomenclatures. Miss Neave laboured under many delusions, one being the belief in the influence of the Jesuits upon the servants and others. The action was brought by her against Mr. Hatherley and Dr. Gardiner, but in consequence of the decease of the latter the action was carried on against the surviving defendant only. Miss Neave might make a virtue of necessity, and proudly say, with Charles V., "I do not wage war against the dead, but the living." Mr. Hatherley pleaded that he had signed the certificate *bonâ-fide*, and he happily gained the day; in legal phraseology, he was not guilty of culpable negligence in certifying that Miss Anne Alice Neave was insane on the 12th of July, 1881. We are glad to have it said by Lord Coleridge, whose sympathies are not always on the side of mental physicians, that it were "lamentable" if, in such cases as these, medical men were "to be made responsible for honest mistakes, for the consequence must be that those who were in the higher ranks of the profession would refuse to sign certificates in lunacy cases, and alleged lunatics would be at the mercy of men in the lowest ranks of the profession." This is actually coming to pass. Yet there are those in even our own profession who profess to hold that the Lord Chief Justice showed his ignorance in expressing this opinion. A medical journal deems it probable that "nine-tenths of the members of the medical profession, who are in what we presume Lord Coleridge would call its lowest ranks, are more likely to form a safe and clear judgment than those in the higher ranks." Paradox is all very well in its way, but we should have hardly expected that the temptation to write a smart article would have led our contemporary into such a childish ab-

surdity, had we not remembered a certain dissertation some years ago on the resemblance between asylums for the insane and Zoological Gardens. Common-sense is doubtless of the utmost importance in the diagnosis of lunacy as in that of other diseases, and we may assume that it is equally distributed among the different branches of the profession. It is something new to learn that the addition of special experience in a disease unfits a man to form an opinion about it.

To whatever rank, however, the defendant in this case may be relegated—the “higher” or the “lower” in the professional scale—he is to be congratulated on the verdict, and the late Dr. Gardiner also may be congratulated on being at rest where the wicked cease from troubling psychological physicians.

Hillman v. Crosskey.

This trial—another in which a person who had been under certificates took proceedings against a doctor who signed one of the certificates—differs in many very important points from those which have recently been before the public.

The trial was held at Lewes during the Sussex Assizes, and the points at issue had on several occasions been before other tribunals.

It was expected that the trial would have been a very prolonged one, for the first two actions which were down for trial were against the two magistrates who signed the order for the reception of the patient into a county asylum. The order of the magistrates had been quashed, and already one action against them had been tried, and in the High Court the plaintiff (Hillman) lost, there being two judges against three. The question now awaits the final decision of the House of Lords.

By arrangement, the action against the magistrates was postponed till the House of Lords decided on the point of law as to the nature of the “examination” required to be made by the magistrates, and, therefore, the action against Dr. Crosskey alone was tried. As the decision may be appealed against, it will only be necessary to give a succinct account of the trial, not in any way prejudging the questions at issue. The facts brought out at the trial were that Mr. Hillman, an old resident at Lewes, was a man of inde-

pendent means, lived a quiet and regular life, and spent a great deal of time in taking long walks and in coursing. He took a good deal of interest in local politics, and was a strong partisan.

Two of his brothers and one sister had been insane, one brother being at present a patient in St. Luke's Hospital—of which institution Mr. C. Hillman is a governor. There was no evidence of any attack of insanity in the plaintiff before the alleged illness of 1884. The first cause of nervous disturbance followed the discovery of some I.O.U.'s of a friend of his, recently deceased, he being upset by the thought that his trusted friend had not acted honourably.

The plaintiff himself said that he was disturbed, and had a hysterical fit, but that this passed off, and that though he was ignorant of what he did for a short time, this lapse of reason was quite temporary and unimportant. Under cross-examination, he denied most positively all the allegations of the defendant. It was said, and witnesses of position swore, that Mr. C. Hillman had been on several occasions excited in the streets, having accosted several persons and spoken to the police about a conspiracy; he was said to have pointed out certain people as connected with the Fenian conspiracies, especially he referred to a tall stranger, and to his coursing with a white dog; he was said also to have mistaken a lady, the wife of a French nobleman, for a former servant of his family. These were the chief symptoms of insanity which were the grounds for the action of the police, the magistrates, and the doctor.

During the trial and a very prolonged examination and cross-examination, the plaintiff behaved calmly and answered clearly. Every point as to the delusion he denied or explained in a very plausible way. Thus, as to the Fenian conspiracy, he referred to the fact that an attendant in an asylum in Sussex had been proved to be deeply involved in the plots; and he maintained that the doctors considered his ideas about the I.O.U.'s to be delusions, whereas they were facts; and not understanding the drift of his conversation, they said he was incoherent.

He remembered the visits paid to him by the doctor and by the police, and also gave a clear account of his removal to Haywards Heath Asylum.

He described the careful physical examination made of him by Dr. Worthington, but denied having expressed himself as afraid of plots, or in any way speaking or acting

insanely. He remembered also the examination made by Dr. Williams, but here again he denied any of the insane expressions attributed to him.

He spoke very favourably of his treatment in the asylum, objecting only to the pauper's clothes and food, and to his epileptic companions.

He denied having made the statements which Dr. Crosskey attributed to him in the certificates, and accused him, as a second count in this trial, of libel. He said he requested to be sent to St. Luke's instead of to a private asylum, and he said when examined by Dr. Crosskey and Dr. Newth he was as sane as he ever was. He recounted his admission within a fortnight to St. Luke's and his examination by Dr. Mickley, and then his removal by his lawyer, and his subsequent visits to Drs. Maudsley and Savage.

Thus far the examination brought out the chief facts of the case, which may be here briefly recalled. After a nervous shock, the plaintiff acknowledged that he suffered from a loss of recollection of what he did for a short time; during this time it was alleged that he did and said strange things, indicating, according to the defendant, a state of insanity, with delusions of a conspiracy against him. His friends declining to act, and the police being informed that he was a dangerous lunatic not under proper care and control, took the only step open to them and sent him to the county asylum, whence he was transferred under two fresh certificates to St. Luke's, where, after two days' residence, he was, on Committee day, discharged as not being of unsound mind. He then consulted independent medical experts, who were unable then to detect insanity. Dr. Savage was the second witness called, and he detailed the facts of his examination; he could find no evidence of mental loss, nor of the presence of delusions; the plaintiff did not appear vindictive or suspicious, and acknowledged freely his temporary nervous illness.

He said insanity, with delusions about conspiracies, was a dangerous form of insanity, and usually took some weeks to develop; sleeplessness might precede such symptoms. He made a distinction between insane people requiring treatment and those needing control; the former might be treated at home. As a rule, cases of delusional insanity needed removal from home; such removal might speedily effect a cure.

Dr. Mickley gave evidence as to his knowledge of the

plaintiff and to his examination of him on his admission, and of his frequent conversations with him while in St. Luke's. He failed to detect any signs of insanity in him, and reported him as not being then of unsound mind.

This was the evidence for the plaintiff.

For the defence, the defendant spoke fully of the examination of the plaintiff and of his change in habits and manner. He repeated his statements made in the certificate, and said he considered Mr. Hillman at the time to be suffering from insanity with delusions, and to be a dangerous lunatic. He had had special knowledge of insanity.

Dr. Williams and Dr. Worthington both clearly described Mr. Hillman as having delusions while at Haywards Heath, and also as being excited; they had no doubt but at that time he was insane, and required to be under care and control.

Many other witnesses from Lewes, both medical and lay, gave evidence as to the conduct of Mr. Hillman before the certificates were signed, and all said he was excited, some said he was threatening, and that he had delusions about a tall Irishman, the head attendant of St. Luke's, a black dog, and a woman who had been in his service.

Baron Huddleston summed up at great length and with conspicuous clearness.

He pointed out the main issues, as to whether the doctor took sufficient care to find out what was the state of the plaintiff, whether he complied in every way with the requirements of the Statute, and whether he did this in all honesty and without any malice.

He referred, as he is now in the habit of doing, to what he considers the unsatisfactory state of the law, and the hardship involved in sending a person of Mr. Hillman's position to the county asylum; but he left it for the jury to decide as to whether Dr. Crosskey acted as he did on sufficient grounds and with due care.

The jury decided in favour of the defendant.

It only remains for us to consider a few points in this trial, which will probably have to be again noticed when the decision of the House of Lords is given.

The evidence of temporary mental aberration was very strong indeed, and when men of the experience of Dr. Williams, Dr. Worthington, and Dr. Newth give it as their opinion that the plaintiff was irresponsible and dangerous, he would be rash who opposed it; and this was strengthened

by the long personal knowledge which the defendant had of the plaintiff.

The next point is the one as to the propriety of sending such a patient to the county asylum, and though we may think the step was taken hastily and inconsiderately, yet we have to remember the risk which is run by allowing a person with marked delusions of suspicion to be at large.

If there was a fault in this respect it was with the friends of the plaintiff, who declined to act, and not with the doctors.

Though, at first sight, a conflict of medical evidence may appear to have existed, this, we think, was not the case; the doctors' opinions were formed at different periods, and we all know a man may have delusions to-day and may be free from them in a fortnight. The insane relationships of the plaintiff would, in our opinion, render this rapid recovery more likely.

PART II.—REVIEWS.

Physiology 'v. Metaphysics in Relation to Mind. Reprinted from the "Lancet," by Dr. WALTER HAYLE WALSH, M.D., &c., pp. 23.

The Colloquial Linguistic Faculty and its Physiological Groundwork. By Dr. WALTER HAYLE WALSH, M.D., &c. John Bale and Sons, pp. 80.

These two pamphlets from Professor Walshe will be hailed by many an old pupil with great interest, and among his former pupils there are many readers of this journal who will be pleased to see that his studies are directed of late to subjects congenial with their own.

The first pamphlet shows in what direction and to what school of philosophy his meditations have led him. He remarks that few can have failed to notice how common it is to hear psychologists, if referred to at all, stigmatised as Atheists; if still common, surely it is becoming less so, or the psychologists are becoming bolder, for those who openly avow these views are certainly more numerous than formerly.

Time was when, as Dr. Walshe writes, it was the verdict of the masses that *Ubi tres medici, ibi duo athei*, but he asks:—

"Is there really any fair ground for the inference that because physiology strives to trace out and interpret the conditions of the connection between brain substance and mind—ergo, those who labour in its field are of necessity Atheists?" Are we to abandon the study of the human body lest its study should reveal some error in the system of metaphysics? "Blaise Pascal (1623-62) strove to dissuade his generation from following out the Copernican system to its issues because it maintained the heretical doctrine of the movement of the earth;" and history, even quite modern history, is full of such fears. Had not geology to pass through such a stage of trial and calumny?

Dr. Walshe gives, as a prelude to his remarks, "a very rapid glance at the notions advanced by metaphysicians and theologians on the nature of mind and generation of thought," and of views concerning the soul.

"Metaphysicians hold," he says, "that the act of thinking is in all its stages and all its factors a non-material process."

Descartes assumed "that there exists a spiritual, non-extended, indivisible substance, an objective, immortal entity, superadded to, and independent of, brain, which thinks, feels, and wills—a substance cognizable by self-consciousness alone, and which is, in fact, the thinking principle or proper soul." "Mind thus becomes absolutely and wholly an extra-cerebral product, and the possible offspring of activity on the part of the 'soul' alone."

"We find that with some philosophers the soul is a local, with others a universal existence; with certain thinkers an essence, with others a substance; with a third group a principle. With some an immaterial essence without form or extension, with others immaterial, yet possessed of those attributes of matter. With the majority a simple, with the minority a compound existence, and with a small fraction of the latter a tripartite body, of which each division is again subdivided into three."

The various views of different thinkers, from Descartes to Kant, are examined. "In the firm analytical grasp of that extraordinary thinker, Kant (the most tremendous disintegrating force of modern times), the past fallacies concerning the nature of the soul had scant chance of mercy. Ancient philosophic creeds crumbled to dust before him." And he asks, "who is any the wiser by accepting Kant's mystic reveries on the Ego, which exists beneath, or rather outside consciousness a noumenon."

"Reaching next the modified or hybrid metaphysical and physiological school of the present day (the former element largely predominant), Dr. Walshe says: We find one of its most eminent representatives—Bain—seeming to teach that, whatever it is, the soul has but loose connection with the body. The body might, he assures us, have its bodily functions without the soul, and the soul might have its psychical functions in some other connection than our present bodies."

"The physiologist of the pure observation school may admit his deficiency in critical training for the just estimation of metaphysical methods; since metaphysicians are found occasionally confessing, nay, boasting, that they fail to understand each other." Lewes, in one of his works, asks how it is that there are so many systems of philosophy, and that, in fact, every writer on the subject is at the same time the exponent and the founder of a new school. We hear of a Spinozist, a Hegelian, a Kantian; of the principles of Schopenhauer, of Fichte, but how strange it would seem if we heard of a system of chemistry of different chemists.

"We metaphysicians have first raised a dust," said Berkeley, "and then complain that we cannot see."

The author next speaks of the theological speculation concerning the nature of mind and soul. Theology, he says, "seems to possess no special or distinctive standpoint of its own," but is a compound of fragments of ecclesiastical dogma and the current metaphysics of the day.

"The early fathers of the Christian Church, without exception, believed in the existence of soul as something super-added to body," and it may be, with many, this is the most prevalent notion still.

"The Positivists, eschewing both spiritualism and materialism in this field, decline even to investigate the mystery of the mind, as lying beyond the pale of possible comprehension, while they scout with withering scorn the assumption of the metaphysicians that they have settled the problem of mind by calling it spirit—a word which is for Comte and his followers *vox et præterea nihil*."

"Such being the acquisitions in the past, what is the reasonable prospect, Dr. Walshe asks, in the future?" "The impotence of pure metaphysics is beyond dispute. A thousand years of introspective dissection of self-consciousness, and of the play with bewildering passage of words, more or less equivocal, and of phrases more or less conventional, has

ignominiously failed to reveal the essential nature of one or the other."

He concludes thus: "Biology seems to be, in truth, the working instrument of possible indirect revelation granted to man, in respect of this special enigma, by the Almighty First Cause." "But scarcely can we, in our most ardent moments of scientific enthusiasm, hope, through physiology, to fathom the mystery to its lowest depth—to grasp the true nature of the force that sets to work the dynamic and statical activities evolving mental phenomena out of brain."

The first part of Dr. Walshe's brochure, "The Colloquial Linguistic Faculty and its Physiological Groundwork," is occupied with showing how rare an accomplishment it is to speak or write a foreign language correctly. He examines critically the statements which have accredited such a power to different celebrities, and, by his examinations of the facts, throws considerable doubt upon the achievements of many of these. When we bear in mind how rare indeed it is to find anyone who speaks and writes his own language correctly, we can have no difficulty in conceding this point to the author. Cobbett claimed that he had detected a grammatical error on the very title page of Lindley Murray's grammar, and that the error was in a quotation from "Blair on Rhetoric," and the object of the quotation itself curiously was to show the value of correct writing. And, besides errors of grammatical construction, are there not provincialisms—errors in composition, in pronunciation—and dialects, Scotch, Irish, and American, Indian also—to confound and confuse the natives as well as foreigners.

Dr. Walshe first points out that the words "linguistic faculty" may be used in several significations; but he is concerned in his present enquiry chiefly with "the power of rapidly acquiring and correctly using the various languages of the day in speech and in writing."

He remarks that, while the ability to speak a foreign language correctly is not common, the power of composing in a foreign language is yet more rare.—"Rare, indeed, are the authors—may they not be counted on the fingers?—who can be said to have written even in two languages as if to the manner born."

The second part of Dr. Walshe's treatise, however, is, to us perhaps, the most interesting, and in it he investigates the causes of this rarity of the colloquial faculty; and

reviews (p. 35) the conditions regulating the colloquial linguistic faculty. These he considers under the heads—

“A. Cerebral.—1, formation word-centre; 2, emission word-centre; 3, audition centre; 4, tone-centre; 5, motor word-centre; 6, imitative faculty; 7, memory; 8, automatism; 9, unconscious cerebration; 10, anastomatic association.

“B. Muscular.

“C. Sensuous.—Organs of hearing and sight.

“D. Social.—International intercourse; foreign marriage; social status.

“E. Personal.—Sex; age; temperament; health; heredity.

“F. National.”

Under these heads the author proceeds to make his comments, which, since they are given in a very concise form, it will be difficult further to condense in this survey.

Dr. Walshe, *in limine*, clearly sides with that school of mental science, which is that now generally received by the English physiologists—English, for it is doubtful to what extent the Scotch and Irish scientists acquiesce in the doctrines, represented by Spencer, G. H. Lewes, Mill, Maudsley, Bastian, and others, and, in fact, of all who have lately written in England. He writes:—

“The metaphysical conception of mind as a spiritual entity, one and indivisible, existing and acting independently of the brain, may be dismissed from consideration, the advance of the physiological psychologist having demonstrated its fallacy.”

Dr. Walshe next traces the history of the views regarding the cerebral functions from their earliest origin.

As regards word-centres, he remarks: “When the part played by the cerebral substance in the genesis of thought first dimly dawned on physiological intelligence, *the brain, as a whole*, was supposed to enter a state of activity as the imperative condition of the processes of ideation, volition, &c. Willis is commonly credited with having originated the notion that special functions are discharged by special areas within the brain; but he is supposed to have followed a previous physician. The prevalent ideas, however, in Willis’ time were that the various emotions and feelings arose from the joint operation of the spirit, acting on the heart and the brain. These were mere crude speculations; but the funda-

mental belief that different functions were performed by different parts of the body was an almost material conclusion from perceiving the different organs and different parts of organs. A similar notion doubtless gave rise to the doctrine of the phrenologists, which, though it rested at first on pure speculation and the most crude observation, yet seems to have made a fortunate commencement to the hypothesis that the various mental faculties had separate foci. "The absurdity of phrenologists, says Herbert Spencer, in presenting their doctrine as a complete system of psychology, suffices to repel all students of mental science." They professed to have made, indeed, a complete analysis of mental products, and to have reduced them to their simplest elements, which was going to a length as remarkable for its audacity as for its crudity; but, as the author remarks, "Gall gave a new impulse to the study of cerebral physiology, and merits a high place among its cultivators."

"Herbert Spencer admits phrenology to be the administration of a general truth, and holds emphatically that different parts of the cerebrum must in some way or other subserve different kinds of mental action."

It is certainly noteworthy in connection with Broca's convolution that phrenology commenced on pure hypothesis, but, aided subsequently by observation, should have fixed upon prominence of the eyeballs, as denoting linguistic aptitude. "Unfortunately," writes Dr. Walshe, "for this doctrine, people remarkable for their deep-set eyes were every now and then found to be gifted with singular fluency of talk, conversational and oratorical, while the converse association of protruding eyeballs with tameness of speech proved to be extremely common."

It must be remembered that if Broca's convolution were unusually large it would probably, but not necessarily, encroach upon the roof of the orbit, and thus give a protuberance to the eyeball; but if the brow, or anterior portion of the cerebrum, or the frontal convolutions be largely developed, they would cause the brow to jut out and overshadow the orbit, in which case the eye would no longer be prominent but *appear* receding. Now, these frontal convolutions have been accredited to be the seat of the purely psychical functions, and by some phrenologists as the seat of the observant or perceptive faculty. And it is certainly true that prominent brows are to be found chiefly in persons of a practical turn of mind—men of great

observation, great collectors of facts—and in these the eye-ball may be so deeply imbedded as to appear receding and small. There are some examples of this conformation among medical celebrities of the present generation well known to Dr. Walshe, but, of course, one cannot name them here.

Nevertheless we must accept the verdict of Dr. Bastian (p. 520)—the System of Phrenology of Gall and Spurzheim was fallacious in almost every respect.

But localization now is admitted by all practical men, and may be considered as proved.

Dr. Walshe touches upon the question whether localities are rigidly specialized for particular function. He asks: "Where does cell differentiation, in its progress towards infinitesimal minuteness, close? What is the amount of cell structure told off for this or that kind of manifestation amid the sum total of cerebral act writers? In other words, how many cells go to form a faculty ganglion?" We may, with equal cogency, ask, What are the most simple or elementary faculties which should have such special organ or ganglion cell or collection of cells? Are the separate localities to be the habitat simply of an impression or of an idea, and if the latter, of a concrete or abstract idea?

Dr. Walshe accepts the dictum of Brown-Sequard, that "motor or other centres, as commonly conceived—that is to say, as agglomerations of cells having one and the same function, and which form a more or less definitely limited mass—do not exist. This, indeed, appears to be the conclusion of most who have examined the subject—as Hughlings Jackson, Bastian, &c.—*i.e.*, admitting the principle that there are special areas for particular function, that such areas alone serve a given faculty, is not admitted.

Hughlings Jackson wrote—West Riding Reports—"I have never believed in what I call abrupt localizations. I have never acceded to the opinion that speech is to be localized in any one spot, although I do believe most firmly that the region of Broca's convolutions is, so to speak, the yellow spot for speech, as the macula lutea is the centre of the greatest acuteness of vision, although the whole retina sees."

This, however, is a digression from our author, who proceeds to enumerate the stages of speech-production, and which he divides into nine—from the first afferent stimulus to the ultimate or efferent motor production. He considers the part played by the visual and auditory word centres to

the offices played by the different parts of the nerve centre in phonation.

This portion of Dr. Walshe's work is so elaborately traced that it is too long for extraction, but it has special bearing upon the variations of morbid symptoms in amnesia, aphasia, dysphasia, and agraphia, and is particularly worthy of careful study by us; but we must refer the reader to the work itself.

After the description of the mechanism of speech the difficulty in the acquisition of more than one language is more easily understood, and Dr. Walshe proceeds to examine how it is that we find that some individuals have a greater aptitude for acquiring a language than others.

This leads him to the question of genius. As this question appears to have been one on which he has expended much thought, we give his definition:—

“Genius in general,” he writes, “may, I think, be defined as the irrepressible energy of a differentiated, highly dynamised, and perfectly organized cluster of brain cells (cerebral centre), which, through use, increases in potentiality and in readiness of assimilating nutrient material from the interwoven neuroglia, and eventually becomes extra nourished and extra vigorous” (p. 52).

We ought, perhaps, to accept this definition as one *ex cathedra*. But Dr. Walshe appears to invite one to discussion by the words which precede his enunciation of it. He says, “*may, I think,*” be defined. Therefore we would ask, Is genius an energy?—may it not be simply a potentiality?—and does it depend upon its condition of extra nourishment? Is it not rather a gift *ob ovo*, and dependent on conformation? If it were an energy highly dynamised, should we ever have it in conjunction with indolence or inactivity? And undoubtedly conformation is clearly the cause of the opposite condition, or idiocy. Virchow's studies of the anomalies in the order of the synostosis of the skull led him to the opinion that in many, if not in all cases, deficient intelligence was due to an abnormal order in the closure of the suture, by which different areas of the brain were encroached upon.

And if we admit special areas for special functions, it may be readily conceived that these being in different degrees of potentiality in different individuals, different characters or inclinations would be the result; and if differences resulted from such cause, it is obvious that certain faculties might be in excess and certain others deficient.

It is very certain that various gifts of special kind may

exist without the individual being at all remarkable for general intelligence. This is especially noted by the author, who cites the case of Senior Wranglers found incompetent at sums in common addition.

But Dr. Walshe, whose genius seems to lie in marshalling facts in any quantity to support his conclusions, relates numerous instances of persons having special gifts for given subjects who were yet very dunces in a kindred question.

Among others he mentions the case of a lad with great aptitude for mathematical propositions, who yet was unable to spell. He remarks, however, that correct performance of the spelling centre is not necessarily associated with manifestation in the speech centre.

"There can be no doubt that the difficulty in the way of practically acquiring fresh languages, both in speech and writing, are seriously increased by the strain put on the spelling centre. The adoption of the phonetic system would certainly smooth the way among educated people to the acquisition of fresh tongues."

The author speaks next of an audition centre and of a tone centre. On this point Dr. Walshe, as is well known, is an accepted authority, having given to the world a learned treatise on "*Singing Physiologically Considered*."

He next speaks of the necessity of the gift of the imitative faculty and of memory in acquiring a new language. There is no doubt that the memory shows a greater aptitude for particular subjects and for different modes of acquiring acquaintance with subjects. Thus one man can understand a subject through the organ of hearing (audition centre); another must see what he has to impress on his memory. Such an one, in reading, can refer readily to the part of the page in which a fact was explained, and so on; one man can remember the argument readily; while another can more readily recall the words. Some of the artificial systems of pneumonics are based upon the reduction of any idea to its concrete and physical appearance.

"In reproducing language memory plays a triple part—acoustic, ideal, and motor." The present writer has elsewhere stated it to be his conviction that memory and want of memory depend upon the state of the blood supply, and if so, we need not be surprised to find idiots with extraordinary memories, and we may find several well-marked examples of this fact at Earlswood.

Dr. Walshe next considers the other conditions, viz.,

automatism, and unconscious cerebration, all of which are interesting, not only in considering the linguistic facilities, but in studying their influences in linguistic symptoms.

The author next enumerates the conditions of life which favour or hinder in the acquirement of language, especially foreign language, and in considering the national influences we draw up the following table arranging European nations in the three subjoined groups :—

<i>Plus Facility.</i>	<i>Media Facility.</i>	<i>Minus Facility.</i>
Dutch.	Irish.	English.
Poles.	Scotch.	Italians.
Russians.		Spaniards.
Swedes.		French.
Danes.		
Northern Germans.		
Austrians.		
Greeks.		

Dr. Walshe says the preponderance shown of conspicuous skill among the northern and north-eastern nations of Europe clearly points to the activity of race influence.

It would seem to depend on the varying necessity for cultivating a foreign language among the different races.

Thus Dutch, Poles, and Russians often could not make their way without the use of some other language, while French can find interpreters wherever they go. This cultivation by necessity of a foreign tongue, descending through many generations, may influence the organism concerned, even as the now natural absence of tails in the Manx cats has been supposed to have arisen from the practice of curtailing this appendage, first practised in obedience to fashion.

W. H. O. S.

Die That-Sachen der Vererbung in Geschichtlich-Kritischer Darstellung. Von Dr. EMANUEL ROTH. Berlin, 1885.

The title of this book gives an accurate idea of its contents. As the facts of heredity are presented to the mind in a concrete form, whose mystery has escaped scientific analysis, they are interesting even to non-scientific readers, and are of unquestionable importance to all. It does not appear that the author has enjoyed any special advantages in the way of investigating the hereditary transmission of mental qualities beyond what is possessed by most members of the

medical profession ; but he has studied almost all the most important books and papers on the subject, and he presents the different views with fairness and judgment. We should have liked if he had used a little more critical vigour in summarily rejecting or missing out theories or statements which have too long enjoyed a prescriptive right to be quoted, but which are now practically abandoned. On the whole, it may be said that Dr. Roth has succeeded in giving us, within the compass of 147 pages, all the most important facts yet ascertained upon hereditary transmission. He does full justice to the labours of our own countrymen—Darwin, Buckle, Spencer, and others being frequently quoted.

Dr. Roth does not enter with any detail into the hereditary transmission of insanity. The last chapter, "On the Inherited Qualities of the Human Mind," while showing a profound knowledge of psychology, ancient and modern, is too short for the treatment of the many philosophical problems which the author glances over.

In common with most psychologists of the day, Dr. Roth is in favour if not of innate ideas, at least of innate tendencies of thought. He considers the capacity of different human races more equal than is generally believed.

Dr. Roth justly remarks that it is only in our own time we have been able to show the difference in the structure of the nervous centres in the new-born child and the adult. In the infant the medulla and spinal cord have attained a more mature stage of organization than the brain. Those portions of the brain which, in the adults, are the driest, have, in the new-born child, the greatest proportion of watery fluid. In citing the observations of Jastrowitz on the gradual organization of the nerve-fibres of the brain and cords out of fatty granules, Dr. Roth does not refer to the instructive observations of Dr. Fuchs on the development of the axis-cylinders in the various regions of the brain of the child.

In a book of this kind the author's information must be very wide, and a good memory is needed to avoid making slips. Very few of these have been noticed. We may give one example : Dr. Roth mentions as men of genius remaining without posterity—Cæsar, Newton, and A. von Humboldt. Cæsar, who was very dissolute in his amours, left one son by Cleopatra, and Newton was never married. The effect of absolute continence on mental power is worthy of inquiry. It is singular that our greatest historians, Gibbon, Hume, and Macaulay, were unmarried men.

Lectures on the Diagnosis of Diseases of the Brain. By W. R. GOWERS, M.D., F.R.C.P., Physician to University College Hospital and the National Hospital for the Paralyzed and Epileptic. J. and A. Churchill, 1885.

In its scope and in its method this book is, as we are informed in the preface, similar to the author's "Diagnosis of Diseases of the Spinal Cord," and with this book is completed what may be termed a clinical survey of nervous diseases. It is important that the purpose of the book should be recognised; it does not aim at being a systematic treatise, but simply at furnishing the reader with a definite plan of investigation, and at interpreting the symptoms which such investigation might discover. The book is one of great interest, and justifies a somewhat detailed examination.

In the first lecture considerations of a more general character introduce the subject proper. The extreme complexity of a subject which deals with the relations of eight hundred millions of cortical cells (to the preciseness of the estimate we, of course, do not attach importance) is pointed out; but this remark is a little further on tempered by the statement that, considering how numerous they are, the "variety in form of the elements is comparatively small," the fibres varying but slightly, whilst, of the cells, probably not more than a dozen forms, even when the element size is taken into account, are recognizable. Thus the commotion of a vast crowd is transformed for us into the disciplined movements of as vast an army. Lest, however, we should be too elated there comes a sentence we must quote:—

At the same time we must remember that the varieties of form give us no clue to the differences that may exist among the elements of which the nervous tissues consist. Neither microscopical examination nor chemical analysis can penetrate beyond the coarsest outlines of the constitution of living matter.

But even granted that outward form were more reliable as a guide to function we have yet to remember that "it is the arrangement and connection of these elements that constitutes the complexity of structure of the brain and subserves its complexity of function." How true this is a remark by the late Dr. Latham, of St. Bartholomew's Hospital, sets forth. There are, he says, but twenty-six letters in the alphabet, yet these suffice for all language. Hence we see

that, granted even the existence of but few forms of elements, the arrangements of these may yet be most complex.

Dr. Gowers proceeds to consider the modes in which a knowledge of nervous structure has been gained. The scalpel takes us some way, but not far; the selective action of disease, which we owe to Waller, or his method, takes us much farther; then there come to aid us the beautiful developmental facts which we owe to Flechsig, more especially; and lastly we have at our command the experimental method developed by Hitzig and Munk chiefly, in Germany, and by Ferrier in England. As the combined result of all these methods the facts of structure have been largely determined. Certain elementary facts are then insisted upon; of these one is the *unity of the nerve-cell and nerve-fibre*. We speak commonly of these structures as if they were distinct.

They are not really so. The axis cylinder of each nerve-fibre is the prolonged process of a nerve-cell, sharing all changes of nutrition that the nerve-cell undergoes, suffering with it when the cell is damaged. This is the secret of secondary degeneration.

We have here a very simple statement, yet one which will probably cover the ground, and, indeed, which furnishes but another instance that the facts of nature, however apparently intricate, will yet on close examination show a fundamental simplicity.

Another elementary fact, which we find further on, concerns the functions of a group of cells. "Lines of various resistance," we are told, "exist, by which the functional combinations are determined. Education is largely the establishment of these lines of least resistance. Habit depends upon them." Here again we have in all probability a most important truth, which has been most completely developed by Spencer in his "*Principles of Psychology*." On this theory of education consisting in the establishment of lines of least resistance we may explain much. In the child spelling out its lesson we have an illustration of the first stage, that in which the mental pathways are as yet untrodden; in the old man repeating for the hundredth time his favourite story, as also in the examiner repeating himself year after year in questions which all relate to his own subject, *i.e.*, that which by hard study he has made his own, in these examples we have instances of the pathways being so trodden that mental processes naturally enter them as

paths of "least resistance." It is a little humiliating to find oneself thus physiologically unmasked, but we fear it is but too true.

Dr. Gowers very happily illustrates the possible manifold functions of a single group of nerve-cells, a centre so-called, by the steam crane, which, according as certain parts of the machinery are *in gear* or *out of gear*, may be made to revolve, to draw up a weight, or to travel along rails; in this simile we have but to substitute *certain nerve-cells in the group* for *certain parts of the machinery* to perceive the force of the argument. One other reference to this introductory part we must allow ourselves, and again shall quote:—

Not only may one part of the brain contain many centres, but a single functional centre may consist of nerve elements that are anatomically distant—even situated in different hemispheres. Cells may act together when the nerve-fibre is many inches long, as perfectly as if they are only a hundredth of an inch apart, just as the needles of two galvanometers in the same circuit are deflected at the same moment, judged by ordinary standards, whether they are distant a foot or a mile.

This also we would insist on as being a consideration of essential importance. Viewed thus we gain a new conception of the term *centre*, which we see refers to cells or groups of cells functionally associated, but not necessarily locally associated. They must, of course, be structurally connected, and they must, of course, have their locus somewhere within the nervous system; but the local association need not go further than this, *i.e.*, the cells may be situated in distant parts, and yet working together, owning functional unity, may lay claim to be called a *centre*. We must here finish our consideration of the introductory part, the whole of which, only six pages in length, is well worthy of careful thought.

The subject proper of the book commences with a consideration of the cerebral cortex, the topography of which is represented in diagrams of the surface of the brain. The minute anatomy of the cortex is well shown in two drawings, one of which represents the motor type of convolution, the other the sensory type. On the subject of the motor centres in the cortex the statement is made that we do not know whether there is any sharp limitation between the limb centres: "probably there is not, at any rate between the centres for the arm and for the leg." Accordingly we miss in

the diagram representing the functions of the cortex those definite circles which find a place in almost every treatise on the subject. This is, no doubt, a gain, for it is more than probable that sharp limitation does not exist, and those clearly defined circles are apt to carry one too far in the doctrine of localization. Leaving this, we are told further on that the so-called motor area is not exclusively motor, destruction of this part causing not only motor paralysis, but also some loss of sensation in the extremity of the paralyzed limb, together with inability to recognize the posture of the limb, *i.e.*, loss of the so-called muscular sense. Another fact enforcing the same is that convulsions due to disease of this part are frequently preceded by a sensory aura. These are manifestly very important facts.

The pathway of the motor fibres from the cortex to the cord is very clearly represented diagrammatically, as also the position occupied by these fibres in the crista of each crus, and the relative position which the fibres from face, arm, and leg occupy one to another. These points, however, are common property, but on page 14 we find it stated that "the cells of the corpus striatum have no direct relation to voluntary movement," and that "the motor tract passes in an unbroken course from the cortex down to the grey matter from which the motor nerves directly proceed." Is it meant in this statement to imply that the absence of relation is to *voluntary* movement alone, or is it meant to deny the relation of the corpus striatum to movement, both voluntary and automatic? The statement, as it stands, needs, we think, some qualification.

The concluding part of Chapter I. deals with the sensory pathway, concerning which the uncertainty of our knowledge is pointed out. This uncertainty exists for the entire course between the posterior nerve roots and the posterior third of the internal capsule, except, indeed, that the sensory paths are known to cross from one side to the other soon after their entry into the spinal cord.

In Lecture II. the nerves of special sense and the other cranial nerves are considered. The very difficult subject of Hemipopia is clearly handled, and, indeed, it needs to be. In relation to this we are all familiar with a diagrammatic representation of the visual path which we owe to Charcot, and which represents the decussation of the optic fibres as partial in the chiasma and as completed in the corpora quadrigemina. This, we are told, is incorrect, and that

without this completion of the decussation the fibres pass to the occipital lobe, and that we have there the so-called *half-vision centre*. This is very important, and of great interest, for, be it observed, we take cognizance of all sensory impressions, excluding vision, which fall on the left half of the body by means of the right hemisphere. If, now, vision is to conform to this rule, then the right hemisphere must take cognizance of all visual impressions which come from the left half of the *field* of vision; but these impressions are not those which fall on the *left* eye, but those which fall on the *right* half of the left eye and the *right* half of the right eye. (The refractory media of the eye, of course, introduce this complication of reversal.) Unfortunately the subject of hemiopia is not thus simply to be disposed of. The facts of crossed amblyopia, both in functional and in organic disease, lead to the belief in a higher centre of vision, situated in the angular gyrus, in which the whole of the field of vision of the opposite eye is represented. Still further complexity of observed facts hint at a possible representation in this higher centre of the fields of vision of both eyes, so that we should have in each hemisphere a half-vision centre, a whole-vision centre (*i.e.*, one whole eye represented), and a double-vision centre. We cannot but think that our mental vision here is either hemiopic or sees double, for the simplicity is not quite that which belongs to full knowledge.

We must pass over the remaining nerves of sense, though there are many points of interest which we should have liked to have touched upon. In Chapter III. we come to a subject of great importance, the connection between the cerebrum and cerebellum. The prefrontal lobe of the cerebrum and the temporo-occipital lobes of the cerebrum are parts in which lesions of the cortex are without sensory or motor effects. This statement must be qualified so far as the temporo-occipital lobes are concerned, for in the occipital region, occupying an ill-defined area, is the half-vision centre, and in the first temporo-sphenoidal convolution is the auditory centre. With these exceptions the above is true. Either hemisphere of the cerebellum presents us with similar facts. Lesions here also are without motor or sensory effects. Between these regions of the cerebrum and the cerebellar hemispheres there would appear to be the following connection:—Fibres from the prefrontal lobe pass downwards, and occupying the anterior limb of the internal capsule, enter the crus to the inner, *i.e.*, median side of the

pyramidal tract fibres. They proceed to the pons, and here come into relation with the grey matter of its anterior region. Their further course is not traced, but it is surmised that fibres proceeding to the *opposite* cerebellar hemisphere, to the posterior and lateral regions thereof, continue the course. These, then, would be fronto-cerebellar fibres; the other set of fibres are those which, gathering from the temporal and occipital regions of the cerebrum, enter the crista to the outer side of the pyramidal tract, and so proceed to the grey matter of the pons. They appear to be continued by fibres passing to the upper surface of the opposite cerebellar hemisphere anteriorly. From the fact of degeneration following lesion the fronto-cerebellar fibres would appear to be a descending path, whilst the temporo-occipital fibres are probably ascending fibres. If these facts should be substantiated, we should have a connection between the frontal and occipital regions of one cerebral hemisphere by means of the opposite cerebellar hemisphere, the connection taking place in the pons. This very extensive connection of cerebrum and cerebellum is of extreme interest, and more especially since to the regions of the cerebral cortex thus connected the higher intellectual functions have been assigned. As Dr. Gowers points out, these facts "revive the old idea that the cerebellum is in some way concerned in intellectual processes."

The functions of the great basal ganglia are next considered; but we cannot do more than refer to the view according to which the corpus striatum is specially connected with the cerebellum by a descending and ascending pathway, the course being downwards from the caudate nucleus and upwards to the lenticular nucleus. The connection with the cerebellum is probably crossed. "In congenital absence of the cerebellum the corpus striatum is reduced to one-third its natural size (Flechsigs)."

The cerebellum and its functions, more especially those belonging to the middle lobe, are then briefly described. This we must leave, as well as the mystery which still surrounds the functions of the olivary bodies. Some considerations on the cerebral circulation bring this chapter to a close.

Having thus dealt with the needful facts in anatomy and physiology, the next chapter and the succeeding eight chapters treat of the symptoms of brain disease. The importance here of keeping distinct the two elements of

diagnosis, viz., the *locality* of the lesion and the *nature* of the lesion, is in the first place insisted on, and then the mechanisms by which lesions produce their symptoms are alluded to. The first of these mechanisms is that of the actual destruction of brain tissue. The symptoms which follow such partake of the nature of loss, *i.e.*, the functions are diminished, and the extent of this diminution will vary from complete loss to but slight defect according as the functions of the part destroyed are precise or diffuse or are capable of being supplemented by the functions of another part of the encephalon. Short of actual destruction, but acting in the same sense, may be enumerated the following:—compression, anæmia, degeneration, and even inflammation, in so far as it entails the death or decay of tissues. The second of these mechanisms is that of irritation, which may exert its effect in two directions, viz., either it may cause increase in nervous activity, or it may actually lessen such. This latter action is what is known as inhibition. Most morbid processes involve the two actions of *destruction* and *irritation*. An important consideration which finds its place here is that of *direct* and *indirect* symptoms, so called. The terms are not exact, as the author points out, but they are convenient. They signify little more than that any sudden severe lesion results in intense, and probably complete, destruction at the focus of the lesion, but that surrounding this you have an area of greater or less extent in which the tissues are less severely harmed. The symptoms due to such lesion, and immediately following upon it, would correspond to the whole area of complete and incomplete damage; but in the course of time the area of incomplete damage would recover, and with the recovery the symptoms due to this area, and named *indirect*, would fall away, leaving the permanent, or *direct*, symptoms of the focal damage. Hence we must always remember that in sudden lesions the symptoms, as it were, magnify the extent of the injury.

The first of these symptoms of brain disease that Dr. Gowers takes is that of hemiplegia. We shall, however, be able to select but a single point for comment from this chapter. This refers to the instances, few in number, of direct paralysis. It did seem, certainly, that Flechsig's discovery of the variability in the decussation of the pyramidal tracts afforded a clue to the interpretation of these cases, which were hence to be explained as cases of failure of the medullary decus-

sation; but according to Dr. Gowers "it is certain that the medullary decussation, when deficient, is supplemented in the spinal cord." If this is so the explanation falls to the ground. Dr. Gowers' interpretation of these cases of direct paralysis is rather that they are cases of undiscovered lesion in the opposite hemisphere, with which there happens to co-exist an obvious lesion in the hemisphere of the same side, which is, however, latent in its effect.

Interesting as are the chapters which next follow, we must pass them by simply for want of space. Chapter X., however, must shortly claim our attention; it deals with *Aphasia*. Much of this chapter, in particular the first part, is most valuable, and is most clearly expressed. As an example of this, we may give a quotation concerning vocal speech:—

"In vocal speech there are two elements—articulation and phonation. Articulation forms the words on the outgoing current of air; the larynx adds voice to speech, and enables it to be heard at a distance. Voice is merely material for articulation."

This and other parts are so admirably expressed, that we regret that such does not obtain throughout the whole chapter. The subject is admittedly a very complex one, and the fault is probably less in the language than in the obscurity of the subject itself; but the error to us is the admission of much in this chapter into a book which is to be clinical and therefore practical. It is undoubtedly necessary that we should recognize that the nervous processes for language have both motor and sensory relations. Taking the latter, we should understand that we both see and hear things themselves, and then learn to recognize both by the ear and the eye the symbols of language for those same things; whilst on the motor aspect of language we have wherewith to express ourselves, gestures, vocal speech, and written speech. This being so we may get failure on either side, sensory or motor; thus, we may fail to recognize things themselves, or with their recognition their symbols spoken or written may fail to recall the things themselves, and then we are either word-deaf or word-blind; or, all these may be intact and the failure exist only on the expressional side, *e.g.*, vocal speech or written speech may be wanting, and there is then what Dr. Bastian terms *aphemia* or *agraphia*. All this is undoubtedly important, for we must know *aphasia* in all its forms and possible combinations—but beyond this, when

we learn that the loss in aphasia is of particulars first, and then of generals, *e.g.*, of nouns before adjectives, etc, the practical man is likely to add mentally: *cui bono*—will it help me to recognize a case of aphasia? Perhaps the instance we have chosen is defensible on other grounds, for the fact of the loss of particulars before generals in the matter of speech is one which allies itself to the loss of special or more precise movements before those which are more general and therefore less precise—*e.g.*, the movements of the fingers before those of the elbow or shoulder joint, with which our every-day experience of hemiplegia makes us familiar. But the same plea cannot, we think, be advanced in favour of the admission of such debatable questions as the significance of the often-recurring utterances which are frequently observed in the aphasic. Whether these utterances are to be considered as those which were in process of elaboration at the time of the attack—*i.e.*, which the patient was about to speak, as Hughlings Jackson has supposed—or as those which had been just elaborated—*i.e.*, the last words spoken just before the attack, as Gower suggests—surely such questions might be reserved for philosophical disquisitions in our journals. Undoubtedly they are important and very interesting, but are they sufficiently digested? The like objections we think may be urged against some of the attempts to interpret the jargon of aphasics. To these we should prefer some such generalizations as that an aphasic may still have words at his command though he may be unable to frame them into speech, *i.e.*, that without being wordless he may yet be speechless (Hughlings Jackson); and, carrying this mode of analysis still further, and mindful of the painful experience of childhood that we should be prepared for aphasics who, still having the elements of words, *i.e.*, syllables, at their command, may still be unable to combine them to form words. Those who have once grasped the complexity of the mechanism which must underlie language in all its forms, will be prepared for an almost indefinite variety of perversion, and whilst they should be willing to investigate carefully, they will, if wise, be cautious in accepting explanations. We may be wrong in our judgment of the needful here, and would carefully avoid bringing any charge of obscurity which would probably only recoil on our own head, revealing its mental obscurity, still we cannot help feeling that the chapter on aphasia is too long, and admits into a textbook matter which at present is not possessed securely.

With this very inadequate survey of a book which has given both much instruction and much pleasure, we must bring our remarks to a close. It is true, as it is true of no other system of the body, that method is essential in the investigation of nervous diseases—method and fundamental principles. No amount of experience, of storing of individual instances, however accurately observed, will replace such, for so varied are the manifestations of nervous disease, that our store of individual cases, however large, will never furnish us with exactly the counterpart of the case under our observation. It is for this reason that Dr. Gowers' book is of such value, insisting, as it does throughout, on method, and laying down for the student principles which we think he may trust to. We should gladly have made our survey more complete, and have devoted some space to the admirable chapters on diagnostic pathology, and on pathological diagnosis, which conclude the book, as well as to much else which we have been obliged to pass over. But, after all, a reviewer can scarcely do more than present selections, and this task, where all is so good, is not a light one.

H. S.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *Asylum Reports.*

(Concluded from page 272.)

Albert Royal Asylum.—The report presented by the Managers to the subscribers is a full and satisfactory record. It shows how liberally the institution is supported by the public and how deserving it is of such assistance. The short history given is one continuous record of success and progress. A detached infirmary has been built and furnished at a cost of £5,670, of which £5,000 were contributed by a gentleman and his wife. The benefactions lavished upon this place are very creditable to human nature.

Dr. Shuttleworth, in his report, brings many subjects of interest under notice, and we will reproduce the following paragraph on the condition of discharged patients.

“Inquiries were addressed to the friends of the 20 election patients discharged in 1882 with regard to the progress of the latter. The replies may be summarised as follows:—Five are doing very well (two boys earning wages, three girls very useful to their friends in domestic work); five are fairly useful at home; five are doing

nothing, and of the other five three have been sent to county asylums, one to the union, and the fifth, after having worked for wages at a tan-yard, was at his own request engaged to assist at the Royal Albert Asylum. In my last report I stated my opinion that more than half of the 20 cases 'had so far profited by their training in the institution as to be capable of contributing by their labour to their own support,' and the discrepancy between this estimate and the number profitably employed emphasizes the suggestions made last year as to an organisation for procuring suitable situations for discharged patients. It is gratifying to be able to add that the patients referred to in the last report as earning wages continue to do well. The boy (M. P.) whose letter was quoted is earning 10s. per week in the bleaching department of a mat factory. He lately visited his old friends at the asylum, as have also two of the other lads in situations."

From a pecuniary point of view these results can scarcely be considered satisfactory, but there are higher and better reasons for persevering in such work as is undertaken in the Albert Asylum.

Salop and Montgomery.—The extensive alterations and enlargements of this asylum are in progress, but they do not advance so rapidly as they should.

The concluding sentence of the following extract from the report by the Commissioners is very suggestive of the radical difference which exists between some of the views held by the English and Scotch Boards. Without expressing any general opinion as to which are nearest the truth, we cannot help saying that in the present instance the English Commissioners suggest a line of management which if thoroughly followed out would lead to the instant and extensive use of seclusion and restraint. If every possible source of danger is to be removed from the reach of patients, what will be left in the way of furniture and clothing? The paragraph is as follows:—

"In the case of the suicide, the woman appears to have escaped from the observation of the attendants while going to or returning from evening chapel, and to have found her way to the pond in the garden in front of the asylum, in which, having been missed at bedtime, she was found dead. We have inquired further into the case, but without eliciting any facts in addition to those reported by Dr. Strange. It appears to us that the charge nurse of the ward committed a grave error in interrupting, as she did, the counting of the patients leaving her ward for chapel, but there must also have been want of supervision by the attendants who conducted the patients there. The hour of service is 6.30. It may be a question whether it is safe to have it so late except when the days are long enough to permit of going and returning by daylight. The pond in question having by this occurrence been shown to be a possible source of danger, the Committee will doubtless consider the propriety of filling it up."

We most sincerely hope that the Committee will do no such thing. There is now a second assistant medical officer.

St. Andrew's Hospital, Northampton.—No fewer than 76 patients received assistance from the charity fund during the year.

Extensive building operations are in progress. These include a recreation hall, drawing-room, dining-room, steward's offices, stores, &c.

There are now two ladies' companions, and an assistant head attendant has been appointed on the male side.

The employment of gentlemen whilst resident in asylums has always been a matter of more or less difficulty. We have always advocated out-door work, no matter what the social status may be, and it is satisfactory to find that Mr. Bayley's experience supports our recommendations. He says:—"The experiment of putting the patients to farm work has been most successful; they have improved in health, some of them are much better mentally, and they appear to be perfectly happy and contented. Moulton Park Farm will in this respect be a great acquisition to the institution. Every year's additional experience confirms the opinion I have always had, that out-door active employment is of the greatest importance in the treatment of the insane. No matter what their former social position or occupation may have been, nor how demented they may appear to be, a few weeks' work on the farm or garden improves their general health, rouses them from their lethargic state, and in many cases starts them afresh in life.

"Our case books contain the history of several cases of public school boys, and university students, who have been under care in this hospital, and are doing well in the world, who owe their recovery from a state bordering on dementia to the work they did with spade and wheelbarrow on the garden and farm here."

Somerset and Bath.—Much attention has been paid to the prevention and extinction of fire, and considerable structural alterations and additions are in progress.

Dr. Wade reports that during the first two years there has been a marked increase in the number of cases admitted suffering from general paralysis and other fatal diseases of the nervous system.

As bearing on workhouses as places for the accommodation of harmless lunatics, the following paragraph from his report may be reproduced.

"I have made several efforts during the past year to discharge to the workhouses quiet and harmless patients, with scanty success. In one case the patients were returned in a very few days, it being perfectly evident that no effort had been made by the workhouse officials to take care of them, as the patients were brought back in the same quiet state in which they were discharged. It is clear then that we cannot look to the workhouses of this county, as at present constituted, to relieve us of our surplus insane population."

Two murderous assaults were made on attendants by patients. In one case the external table of the skull was fractured.

Staffordshire. Burntwood.—In the Commissioners' report mention is made of a dangerous patient who stabbed two of his neighbours. He is addicted to picking up articles which he contrives to secrete and sharpen.

As a small contribution to the statistics of suicide, the following figures may be extracted from Dr. Spence's report. Of 153 admissions 58 were stated to be suicidal, and 26 had made a positive attempt at self-destruction shortly before admission. The various methods adopted were :—

	M.	F.	Tl.
By cutting the throat	6	1	7
„ stabbing	1	0	1
„ jumping out of window.....	4	0	4
„ drowning	2	0	2
„ hanging	1	3	4
„ strangling	1	3	4
„ burning	1	0	1
Not ascertained	0	3	3

Staffordshire. Stafford.—It is reported that the extensions are progressing satisfactorily but very slowly. The female block is now occupied by 145 patients.

A second assistant medical officer has been appointed. The efficiency of the night supervision has been increased, thus greatly adding to the security of the epileptic and suicidal patients.

Suffolk.—Through no fault of Mr. Eager this is perhaps the most unsatisfactory report of any asylum in England. The sanitary condition of the building has been, and is so bad, that the Commissioners suggest that it should be pulled down, and we are inclined to agree with the proposal. No fewer than 5 deaths were due to diarrhoea, and 3 to typhoid; and during the year there was such an amount of sickness due to these diseases, that at times the ordinary work of the establishment could scarcely be overtaken. But no surprise can be felt at the deplorable state of things when the following paragraph from the Commissioners' report is read :—

“It would be scarcely fair to close this report, however, without expressing recognition of the efforts already made from time to time by the Committee and medical superintendent to remedy some of the many structural defects of the asylum; but if, as Mr. Hodson reports, the whole system of the asylum drainage be leaky, and no continuous flow of sewage be possible in the main sewers (from the enormous size), and if there be no free current of air in the sewers, and the supply of water to the asylum be also unfit, or scarcely fit for drinking and cooking purposes, no delay should take place in discussing any longer whether the asylum is to be abandoned or to be placed in a proper sanitary condition. Immediate action is necessary to guard

against preventible deaths in the building, and costly though it may be to reconstruct the drainage, that cost should be met, or the asylum should be closed. According to Mr. Hodson, the existing sewers are really dangerous reservoirs of poisonous gas; the main sewers are also described by him as generally half-brick culverts, 18 inches wide and 2 feet 6 inches high, the bottom and sides being formed of loose bricks without mortar; they are exceedingly shallow, the crown of the arch being within a few inches of the floors of the wards; many of the old branch drains, he says, are merely butt-pointed agricultural drain-pipes, only the more recent ones being of glazed stone-ware with socketed joints. We agree with Mr. Hodson that the sanitary knowledge of the present day warns us to expect, under these circumstances, the prevalence of disease."

It is impossible for anyone to read Mr. Eager's report without sympathising with him in his difficulties. It shows a man beset on every side, and struggling with cares which might be removed if the Visitors displayed more energy and discretion. It appears to be necessary for Mr. Eager to teach his Visitors the first principles of asylum construction and management.

Surrey. Brookwood.—The Court of Quarter Sessions having called the serious attention of the Visitors to the urgent necessity of transferring chronic and harmless cases as frequently as possible to their friends or to the workhouses, the Visitors reported that it was their practice to do so, and they recommended the subject to the consideration of a joint committee. It was decided, however, that nothing need be done, considering the action taken by the Local Government Board in conjunction with the Commissioners in Lunacy. Dr. Barton reported to the Visitors that no less than 20 per cent. of the patients in the asylum were of this class, and might be safely dealt with in workhouses *with a little extra supervision and a good diet.*

We regret to find that Dr. Barton was severely assaulted by a patient, receiving three blows on the head. Fortunately Dr. Barton has not experienced any permanently bad effects. The patient committed the assault in order that his case might come prominently before the public.

Surrey. Wandsworth.—Dr. Bigg reports that £28 2s. were given from the Benevolent Fund to discharged patients. Such assistance is sorely needed by many on leaving an asylum; but even more is required. An "After-Care Society" should be attached to every asylum, and its work thoroughly organised and carried on with vigour.

Sussex.—Of the 165 patients discharged during the year, 35 were transferred to workhouses and 31 to the care of relatives. It cannot be denied that, in Sussex at least, the plan of transferring harmless chronic cases to workhouses has been most successful.

As Mr. Williams considered the sanitary arrangements inadequate, and rather behind date, he prepared plans for the necessary alterations. He arranged—

1. That the w.c.'s should be in detached blocks communicating with the wards by a passage having cross ventilation.
2. That there should be an average of one closet for every ten patients.
3. That closets shut off from those of the patients should be provided for the staff.
4. That as far as possible no main drains should pass under the buildings.
5. That all waste pipes should be cut off from the main drains.
6. That wherever there was a bend or angle in a soil pipe or drain, an inspection-plate should be built.
7. That as far as possible all traps should be abandoned, and free ventilation substituted.

These plans await confirmation by Quarter Sessions.

From a return made to the Commissioners it appears that £20 are expended half-yearly on second-hand books, and that 18 daily, 50 weekly, and 38 monthly newspapers or other periodicals are purchased for the use of the patients.

Worcester.—Extensive additions and alterations are in progress, at an estimated cost of £35,200.

So far as we are aware this is the only county asylum where the Visitors object to receiving the poorer middle-class at pauper rates. They say:—

“In the last report your Committee stated that they had reason to believe that a number of patients chargeable to the unions were in circumstances enabling their relatives to pay a higher rate than the pauper weekly charge, which covers only the bare weekly board, and does not contribute to the expense of lodging. It is obviously right that patients should, if their means permit, make some payment in respect of the building which, with its appliances and arrangements, tends so much towards the cure and comfort of the afflicted. The moral duty of meeting this obligation towards the county and city rate is not less than the legal obligation of repaying the various unions the cost of maintenance, and the Committee think that this duty should be kept prominently before the relatives of lunatics. They caused inquiries to be made in the various unions, and the result is a considerable annual increase of profit derived from some of the patients referred to, who have been transferred, with the consent of their friends, from the pauper to the private class.”

Dr. Cooke discusses, at some length, the causes which lead to a continued accumulation of lunatics in asylums. He believes that, so far as Worcestershire is concerned, they are—increase of population, and increase of longevity of the patients.

As it is impossible to enlarge the asylum accommodation indefinitely, Dr. Cooke very naturally asks how is the difficulty to be met? He suggests “the establishment in two or three districts of the county, in connection with the most important workhouse in each district, of

special wards presided over by a Committee of Guardians representing the various unions in each district. The wards might be under the immediate superintendence of the master of the workhouse, assisted by one or more skilled attendants, and subject to the daily visits of a local medical practitioner, and to them the chronic and harmless cases in your asylum might, from time to time, be relegated, as well as those idiots and imbeciles who are unfit to be dealt with in the ordinary workhouse wards.

“ If such a system could be adopted, it would be most important that every precaution should be taken to prevent any case being sent to those workhouse lunatic wards which, presumably, might in any way be benefited by being placed under treatment in the asylum. This danger might be obviated by making it compulsory for every case in which the mental unsoundness had made its appearance, say, during the previous two years, to be sent in the first instance to the county asylum. Such a system as your superintendent has attempted to sketch would be simply an elaboration and consolidation of the one already in vogue at some of our union workhouses, notably that of Dudley.”

Wilts.—The Committee having reported that the whole drainage system was in a most dangerous and unsatisfactory condition, the Court of Quarter Sessions authorised the expenditure of £2,000 in necessary improvements. Serious defects were revealed during the progress of the work, sufficient to account for much illness, and to justify the expenditure incurred. Mr. Bowes reports that since the sanitary improvements have been completed a noticeable difference has been perceptible in the atmosphere of the asylum, and its increased purity is evident in a marked diminution in the amount of sickness, and an entire absence of preventible disease, especially that of an epidemic nature.

Yorkshire. East Riding.—Dr. Macleod records a case in which the receipt of a letter threatening to deprive the man of his life was the probable cause of insanity.

The Commissioners recommend that the epileptic and suicidal patients should be under continuous observation at night.

The dining-hall has been enlarged and some other minor structural alterations made during the year.

Yorkshire, South.—This great asylum continues to be conducted with much efficiency. The Commissioners report that they rarely inspect wards in such first-rate order.

Forty-six patients were discharged to the care of friends, and 28 were transferred to workhouses.

Increased attention is being paid to the sanitary arrangements. Although no epidemic disease has prevailed, some cases of erysipelas have occurred—a sure indication of something wrong.

Yorkshire, West Riding.—The accommodation of this asylum continues to be taxed to the utmost, although 109 harmless cases were discharged to workhouses and the care of their friends. Some of

these patients remained out only a short time. The Committee have also requested the Boards of Guardians to send, as far as practicable, only recent and curable cases, and to retain all others in workhouses.

Improvements in sanitary arrangements are being continued. That these are necessary is evident from the occurrence of several cases of erysipelas and dysenteric diarrhoea. Dr. Major is inclined to attribute much of this sickness to over-crowding.

The following paragraphs from Dr. Major's report may be reproduced, as they deal with a most important subject:—

“The rate of recovery for the year (36·4 per cent. calculated on the admissions) shows a slight fall as compared with the corresponding proportion for the previous year. The difference is not great, and would not, perhaps, be of material importance, were it not for the fact, which will be evident on reference to the eighth column of Table III., that the recovery-rate of recent years has been a declining one. Thus, in 1877—my first complete year of office as Superintendent—the rate of recovery was 46·99 per cent.; it was yet higher in the following year (47·77 per cent.); but since then, it will be observed, the decline has been gradual and uninterrupted to the present date. Impartially considered, it will probably be conceded that such a course of events furnishes, of itself, a strong presumption of the correctness of the opinion which I have never hesitated to express to the Committee—that the decline of the rate of recovery can only be attributed to a progressive diminution of the proportion of recoverable cases received for treatment; for there have been the same general arrangements for care and treatment at my disposal, the principles of treatment have remained the same, and certainly there has been no decline in the efforts of the united staff. Moreover, the general deterioration of the cases received is only too patent to all those of the staff who have had experience of the more favourable conditions which formerly obtained.

“It is not necessary to recapitulate here the views alluded to in my previous annual reports, as to the probable causes which have been at work in drawing more and more into our asylums all classes of the insane poor, irrespective of the nature and degree of the insanity laboured under. Such views, it may be mentioned, have been admirably stated by the Scotch Lunacy Board, in their annual reports, especially those for 1874 and 1875. In this connection, however, it is interesting to note specially the fact recently brought out by the English Commissioners in Lunacy, and the significance of which would seem to be unmistakable, that whereas the proportion per cent. of the total number of pauper lunatics treated in asylums continues to rise, the proportion residing as out-door paupers has steadily fallen since 1859, whilst the percentage kept in workhouses has shown no tendency to increase; and this result, which applies to England and Wales generally, applies, I find, very distinctly (still

taking the figures of the Commissioners), to the West Riding of Yorkshire. The annexed figures will probably suffice to prove the correctness of this statement :—

Year.	Total number of Pauper Lnn- atics in the West Riding.	Proportion per cent. of the total number.		
		In Asylums.	In Work- houses.	With Relatives and others.
Jan. 1, 1873.	2879.	59·47.	29·66.	10·87.
Jan. 1, 1883.	4034.	68·9.	25·7.	5·4.

“Every endeavour has been made to promote the discharge of suitable chronic cases, and as many as 113 cases were discharged as relieved or not improved during the year. Nevertheless the wards have remained occupied with chronic cases, the infirm, the imbecile, the epileptic, to a degree beyond what is found, I have reason to think, in the majority of county asylums, and which, indeed, would hardly be credited by those who have not certainly witnessed what is described.

“To those criticisms which are occasionally heard directed against the results of our treatment, and the rapid increase of the number of insane poor, necessitating, constantly, additional asylums for their reception, the reply I conceive to be simple and conclusive. That our rates of recovery are no higher than they are arises simply from our inability to perform impossibilities—to cure cases which from their essential nature, when received, are incurable. Should the cases received for treatment improve in character, the recovery rate will rise, and the increase in the numbers under care will probably fall in a corresponding degree. We cannot refuse cases, however hopeless, however unsuitable we may consider them, when such cases are brought to us duly certified; on the other hand, the removal of such cases to workhouses is, in general experience, attended with ever increasing difficulty and failure. While matters remain thus—and unless met by fresh legislation they will doubtless do so—the annual increase of the number of the insane in asylums can hardly but continue excessive. Meanwhile, as regards our results, the most that can reasonably be expected is that a satisfactory proportion of the curable cases received should, under our care and treatment, be restored, and that a further satisfactory proportion admitting of relief only should be relieved; and these results, it is maintained, have been thus far accomplished.”

In concluding this extract from Dr. Major's report, it is impossible to repress an expression of heart-felt regret that he is no longer the head of the great asylum where he has done such excellent work, and that his health has compelled him to seek relief from the care and anxieties of asylum life in the comparative peace of pure medicine.

Portsmouth.—Various improvements continue to be carried out, not the least being the completion of a hot-water apparatus and the remodelling of the entire closet system on the female side.

A male attendant was prosecuted for striking a patient. He was fined £5, and in default of payment was sent to gaol for one month.

Two nurses and three patients were attacked with typhoid fever. They all recovered, and since the closets were put in good order there has been no return of the disease.

Roxburgh, &c.—It is reported that in consequence of the prevalence of diarrhœa among the patients in the early part of the year, an examination was made of the plumber work and drainage of the building under the supervision of the Edinburgh Sanitary Protection Association, and alterations and repairs were carried out in accordance with their views. The defects discovered were most serious, and fully accounted for the sickness of the inmates.

The following extract from Mr. Grierson's report shows that he had to overcome several difficulties before he got rid of his surplus inmates:—

“Counselled and encouraged by Dr. Sibbald, Commissioner in Lunacy, to whom we made application for help, and aided by Dr. Lawson, Deputy Commissioner in Lunacy, a more earnest effort than any hitherto urged was made. The Inspectors of Poor were asked to hunt over their respective neighbourhoods for such residents as, being needy, might yet be suitable for guardians, and help in the introduction and extension of the method of dealing with those cases where the primary ailment in its subsidence having destroyed aggressiveness, and left only impairment, could be fully disposed of as single patients in private houses, a method acknowledged to be more readily adoptable in many districts than ours, still everywhere where tried found to be laudable and worthy of imitation. It was not—as we had no right to expect, perhaps, it would be—all at once that relief came to us through this effort. The suitable person was not in need, and could only be induced to remove our incapable nominee at sums equalling or exceeding the asylum rate, plus clothing, medical attendance, and other extra outlays. Parochial Boards and their representatives, the Inspectors of Poor, were scandalized and estranged, and the not altogether foreign question was here and there put as to whether it was not the legal as well as the moral duty of the District Board to bear the burden of all sums in excess of the asylum charge, arguing that as in every case the evidences of unsoundness of mind would be found in sufficient abundance to justify a first commitment, their placement outside was but an extension of the asylum plan, minus its responsibility. The needy were also either too timid or too greedy, as was fully shown in the case of our most passive and pliant imbecile, for whom we had asked the liberty of sitting at the cottage door, and playing with an old tobacco pipe, for which he showed the same attachment that children manifest towards a new doll, and the

offered ten shillings a week was refused, and twelve shillings exclusive of extras accepted. Had not Dr. Lawson espoused the cause of the helpless inmate with a warmth, and at the expense of much work and personal inconvenience, we would still be overhung by the crowd. To Dr. Lawson we are indebted beyond a mere expression thereof, inasmuch as he not only scoured our own district, but including the county of Haddington, was enabled to provide us from personal examination and inspection with a list of suitable and willing guardians; this not only relieved us of all whom we judged staid enough at present to warrant their outgoing, but left us a reserve to fall back upon when others of a like kind came to be similarly dealt with."

2. *German Retrospect.*

BY WILLIAM W. IRELAND.

Tuczek on the Pathological Anatomy of General Paralysis.

Our readers can scarcely have forgotten Dr. Franz Tuczek's studies upon Ergotism which were reported in the German Retrospect of the Journal (October, 1883, p. 426). This treatise upon the Pathology of General Paralysis ("Beiträge zur Pathologischen Anatomie und zur Pathologie der Dementia Paralytica." Berlin, 1884) shows the same power of careful observation rewarded by important results.

Exner's new method of demonstrating the tissues of the brain with the aid of the preparations of osmium and ammonia had disclosed the great abundance of the nerve fibres in the cortex cerebri. In the superficial layers these fibres were found to lie horizontally, in the deeper layers to descend vertically. They were found to vary much in calibre, to be largest in the paracentral lobe, and finest in the basal ganglia.

Tuczek finds that by the use of dyes, such as fuchsic acid, methyl blue, hæmatoxin, and ferricyanide of potassium, a differential distinction can be brought out between the nerve fibres in the grey and white substances of the brain. Sahli has indicated the existence of an "erythrophile" and "cyanophile" substance in different parts of the nerve centres, from the varying way they receive colour from fuchsic acid and methyl blue. He has thus been led to deny the existence of naked axis-cylinders. It having been assumed that the peculiar functions of the cerebral cortex lay in the nerve cells, scarcely any attention has been paid to the condition of the nerve fibres in degeneration of the brain. Availing himself of Exner's new method, Dr. Tuczek has studied the lesions in thirteen males and four females who died of general paralysis, paying full attention to the condition of the nerve fibres. These seventeen cases are described

at length, the symptoms, progress of the disease, as well as the alterations found after death, being minutely recorded. The result of the whole study is that in general paralysis the primary alteration was found to be a disappearance of "the cortical association fibres" in the frontal lobes. This wasting, as the disease progresses, goes deeper and deeper, and diffuses itself over the whole brain. The disappearance of the nerve fibres is well illustrated by six lithographic diagrams, showing the advancing stages of degeneration. It is especially the finest nerve fibres which are first affected. Dr. Tuzek compares these association fibres with the bands and connecting rods of a machine, while the wheels represent the nerve cells. He treats the functional derangements of general paralysis as the result of disturbance of association from the isolation of the nerve-cells following upon the wasting of the fibres. Dr. Tuzek is, however, inclined to rebel against the predominant function assigned to the nerve-cells in the maintenance of mental activity. He even quotes with a degree of approval Henle's view that in the white substance of the brain we have to seek the organic substratum of the soul's activity. He is disposed to think that what has been described as neuroglia is often composed of nerve fibres, and questions the view which regards general paralysis as an interstitial encephalitis. He observes that characteristic alterations in the ganglia of the brain have not yet been found in general paralysis. In this he is in accord with Westphal and Fr. Schultze. Many things he tells us indicate that at the root of this disease we have a primary degeneration of the nerve fibres of the brain. These fibres sustain the associated thoughts and movements most sorely tried in the struggle for existence. Tuzek confesses that this will not explain all the symptoms of general paralysis. To account for the rapid changes of mood, the passing from exaltation to depression, from mania to melancholia, he is content, like so many other pathologists, to call in the influence of the vaso-motor nerves.

The following passage will show how Dr. Tuzek connects the symptoms of general paralysis with the lesions which he has found:—

"In this disease we see those motor performances first and especially affected which require the most manifold associations of single muscular motions. Chief of these are speech, mimicry, and the maintenance of the bodily equilibrium. For the due execution of speech we must have the harmonious co-operation of the nerves of the respiratory muscles, of the muscles of the pharynx, palate, tongue, cheek, and lips, the finest quantitative measure of muscular contractions, and the capacity for timing the concord of associated muscular adaptations. All these working together enable us to learn to speak the different dialects of the world, and to sing all melodies. The complexity of the vocal apparatus is thus so great that one can readily understand how a slip in speaking is more remarked than in

any other muscular operation. The articulation of the consonants requires a synergy of more numerous motions than the utterance of the vowels, and we see in the difficulty of pronouncing the consonants, and in the quavering of the voice, the first derangement of motor association. This is the first striking symptom of general paralysis. We know to what stage this disturbance of speech may descend, and how often a babbling sound is all that is left of a patient's linguistic accomplishments. In these last vocal sounds only the vowels remain, especially the A, which is easiest of all to utter."

A Recovery from General Paralysis.

Dr. Tuczek devotes sixteen pages to the description of the recovery of a patient from general paralysis. This was a man of 36, employed in the Post Office. He was dismissed as unfit for his duties on the 6th of August, 1877, and was received into the Asylum at Marburg on the 27th of the same month. The characteristic symptoms of general paralysis are carefully described, and the progress of the disease and the indications of improvement systematically recorded. He was discharged on the 7th of September, 1878, and on the 13th of the next October the Superintendent of the Asylum gave a certificate that, though he had a remission, he suffered from an incurable disease, and was still in a state of mental weakness. In August, 1882, Dr. Tuczek received word that the man was quite well, and had been for a year in the employment of the Post Office. From the last account, dated May, 1884, it appears that, though suffering from swelling of the left foot, he was otherwise quite well and capable, both mentally and physically.

Lissauer on the Pathological Anatomy of Tabes Dorsalis.

Dr. Tuczek finds a parallel to his own discoveries in the observations of Lissauer (see "Neurologisches Centralblatt," 1 Juni, 1885). This pathologist examined the spinal cord with the aid of Weigert's staining method. He describes a bundle of fine nerve fibres descending the cord between the lateral and posterior columns, and sending out fine fibres to ramify among the nerve cells of the cord. This column, which Lissauer believes to have a special function, runs near the tip of the posterior cornua, and on the outside of the posterior roots of the spinal nerves. In twelve cases of tabes dorsalis, sclerosis of the posterior columns, Lissauer found a wasting of the nerve fibres which composed these pillars.

Tuczek regards the inco-ordination in the ataxic gait of tabes as probably the result of the destruction of the fine fibres of association in the cord. Lissauer observes in conclusion that the fine nerve fibres in the anterior columns of the cord do not entirely escape in the course of the disease, which advances from the posterior surface towards the middle of the cord and the anterior columns.

Anrep and Cybulski on the Vaso-Dilating and Vaso-Constricting Nerves.

Most physiologists have accepted the theories of Rouget and Goltz that the nerves which possess the power of inducing dilatation of the vessels have an inhibiting power, like that of the vagi upon the motions of the heart.

Doctors B. von Anrep and Cybulski have published some researches upon this question in the "Medical Journal" of St. Petersburg, of which summaries are given in the "Centralblatt für Nervenheilkunde" (Nos. 14 and 24, 1884), and in the "Neurologisches Centralblatt" (No. 17, 1884).

Nikoljski had stated that he found that the nerves presiding over erection in the dog could, like the vagi, be paralyzed by atropine and excited by muscarin. Using an adaptation of the plethysmograph to indicate the rising distention of the organs, Anrep and Cybulski found that 0.012 of a gramme of atropine introduced into the blood produced no paralysis or weakening of the excitability of the nervi erigentes. The experiments, however, showed that a more considerable sinking of the blood pressure had an influence on the excitability of the vaso-motor nerves.

The tongue has the dilating and constricting nerves apart from one another, as the lingual nerve gives the vaso-dilators, and the hypoglossal the vaso-constrictors. The hypoglossal nerve was first stimulated, causing a contraction of the vessels, and then on stimulating the lingual nerve the vessels were made to dilate beyond their usual calibre. The periods of latency before these effects were produced were about the same on both occasions. The authors derive from their researches the following conclusions:—

1. There is no analogy between the effects of atropine upon the nerves which contract the vessels and the vagi.

2. Nor is there any analogy between the nerves constricting the vessels and those which accelerate the heart's action, because the strongest stimulus applied to the latter cannot overpower the effect of a very weak stimulus applied to the vagus, while a stimulus applied to the vaso-constrictor nerves, both with weak and with strong electrical currents neutralises, the effect of a stimulus applied to the vaso-dilator nerves.

3. A certain amount of blood pressure is a necessary condition for any noticeable widening of the vessels.

4. The latent period for the vaso-dilator and vaso-constrictor nerves of the tongue, as well as the intensity of the induced current required for an equal effect upon the vessels, was about the same.

The authors are inclined to believe in the existence of two separate neuro-muscular apparatus, one of which regulates the contraction, the other the dilatation of the vessels. They quote with favour Exner's view that the dilatation of the vessels is caused by the contraction of the longitudinal fibres of the vascular walls. The elastic coats of the

vessels are stretched by the blood pressure; this causes them to shorten, which, by the laws of physics, increases the lateral pressure of the blood stream.

Erlenmeyer on the Effects of Cucaine in the Treatment of Morphinomania.

Dr. Erlenmeyer tells us ('Centralblatt für Nervenheilkunde,' 1 Juli 1885) that the first reports about the efficacy of cucaine came from America; 26 patients addicted to opium were stated to have been weaned of their unhealthy longings through the injection of cucaine, but from the year 1880 no fresh cases of cure have been published. In Germany Freud found cucaine very efficacious in combating the depression which follows abstinence from morphia in those who have got accustomed to this insidious drug. Wallé regards it as an antidote to morphia, and Richter published a very favourable opinion of its effects. He gave a decided preference to the preparation of Merk of Darmstadt. These recommendations induced Dr. Erlenmeyer to make experiments upon this new medicine. He tried it on eight patients who had become addicted to the abuse of morphia, using the hydrochlorate of cucaine prepared by Merk. He made 236 single observations. In 193 of these pure cucaine was used, in the remaining 43 it was combined with morphia. The highest single dose given was 0.06 of a gramme, but he gave as much as 0.1 in repeated doses in the twelve hours. He generally gave from 0.06 to 0.08 at one dose. Sometimes he found that small doses produced a better effect than large ones. The result of Dr. Erlenmeyer's investigations is given as follows:—

1. Cucaine in doses of 0.1 of a gramme in the day left the cerebro-spinal system quite uninfluenced. Neither the centres of voluntary motion nor of sensation showed the least disturbance of function. There was neither spasm nor paralysis, nor mental excitement, nor heaviness nor somnolence.

2. Cucaine in doses of 0.005 of a gramme had a paralysing effect upon the nerve-centres of the vascular system. This paralysis of the vessels showed itself by increase of the frequency of the pulse, widening of the vessels, diminution of the arterial tension (dirotism), outburst of perspiration, and increase of temperature. The paralysis of the vessels was always very transient.

The acceleration of the pulse began from five to seven minutes after the injection of cucaine, and reached its maximum very quickly, so that from fifteen to twenty-five minutes after the injection it had entirely disappeared. The average increase was from sixteen to twenty-four beats. This increase of the frequency of the pulse is the most constant symptom following the administration of cucaine. Dr. Erlenmeyer illustrates his observations with sixteen sphygmographic tracings, in which the dirotism is well marked. He notices the similarity of the effects of cucaine with those of nitrite of amyl.

3. Cuccaine excited a feeling of heat partly referred to the region of the stomach, and felt in the whole body. In doses of 0.05 grammes, or on the renewal of smaller doses, there was a very unpleasant feeling of distress and faintness.

Dr. Erlenmeyer's experiments on the treatment of morphinomania were disappointing. He found it of some effect in diminishing the longing for morphia for a few minutes, but this was of no avail in combating the unpleasant feelings following abstinence from morphia for the first six or eight days. It had no effect upon the disquiet and sleeplessness, nor on the loss of appetite following abstinence from morphia. He quotes the observation of Panas, that pure eucaïne has no effect in dilating the pupil. It does so only when, through prolonged extraction of the euca leaves, a compound of hygrin is taken with it, probably a hygrin-ether.

PART IV.—NOTES AND NEWS.

THE ANNUAL GENERAL MEETING OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION, 1885.

The annual meeting of the Medico-Psychological Association was held on Tuesday, 4th August, 1885, at the Examination Hall, Queen's College, Cork, Dr. J. A. Eames presiding.

At the commencement of the proceedings, Dr. SAVAGE moved a vote of thanks to Dr. Rayner, the retiring President, for the distinguished way in which he had conducted the business of the Association during the past year, which had been one of unusual disturbance in the lunacy world. The number of Committee meetings, especially of the Parliamentary Committees, had been very many and very prolonged. He would not like to have to say how many hours' work had been continuously thrown upon Dr. Rayner, who had always done his work in a way which was beyond praise, and he was sure they would be only doing a simple act of justice in giving him a very hearty vote of thanks for his Presidency during the past year.

Dr. HACK TUKE seconded the motion, which was carried by acclamation.

Dr. RAYNER, in acknowledging the vote of thanks, remarked that it had been a very great pleasure to him to do the work, of which during the past year there had certainly been a great deal, and he only regretted that their work had had no satisfactory outcome in legislation; but although the amendments which the Parliamentary Committee had drawn up to the Lunacy Bill and submitted to the Lord Chancellor, and which were to a very large extent adopted by his Lordship, had not become law, there was little doubt that those amendments would be put into some future Bill, so that they would not be lost, but would live in future legislation.

Dr. EAMES, in taking the chair, thanked the Association for the honour they had done him in electing him President, and said that he would reserve further observations for his address.

The GENERAL SECRETARY submitted the minutes of the last annual meeting, which were printed in No. cxxxi. of this Journal (October, 1884).

The minutes having been taken as read, were confirmed.

The GENERAL SECRETARY, in the absence of the Treasurer, Dr. Paul, who was unavoidably prevented from attending, submitted the balance-sheet of the accounts for the past year, which will be found on the next page, the same

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Treasurer's Annual Balance Sheet, 1884-85.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
To Balance—Cash in Hand	246 13 9	By Annual, Special, and Quarterly Meetings	33 6 6
To Subscriptions received	264 12 0	By Expenses of Reporting at various Meetings	12 3 0
By Secretary for Ireland	28 7 0	By Editorial Expenses	12 12 0
By Secretary for Scotland	48 6 0	Printing, publishing, engraving, advertising expenses, and postage of Journal	383 11 1
By Sale of Journal, Messrs. Churehill	128 14 0	Prize—Dr. S. Rutherford Macphail	10 10 0
By Interest on £205 7s. 10d. 3 per cents.	5 19 2	Messrs. Wyon, altering Seal and supplying Bronze Medal	12 12 6
		By Sundry Expenses, Printing &c.	7 0 0
		By Treasurer	6 6 0
		By Secretary for Ireland	0 8 3
		By Secretary for Scotland	5 5 0
		By General Secretary	4 2 6
		By Balance in Treasurer's hands	234 15 1
	<u>£722 11 11</u>		<u>£722 11 11</u>

Examined and found correct,

H. RAYNER, Auditor.

Bethlem Royal Hospital,
29th July, 1885.

J. H. PAUL,
TREASURER.

having been duly examined and certified as correct. He explained that the expenditure had been somewhat in excess of that of the previous year, but that the receipts had also increased, and the fact that the balance in hand was some £12 less than at the beginning of the year was fully accounted for by the initial outlay in connection with the seal and bronze medal, added to which additional expense had been involved by the numerous meetings which had been held during the year.

Dr. HACK TUKE said that the annual expense of the medal would be very small. The heavy cost of last year was due to the alteration of the die belonging to the Association.

Attention being drawn to the large difference every year between the expenditure of the Secretaries for Ireland and Scotland, Dr. RUTHERFORD explained the cause of the difference, and it was agreed that the principal items of the expenditure should in future be shown.

On the motion for the appointment of Officers and Council for the ensuing year,

Dr. RUTHERFORD said that he had to tender his resignation of the Secretaryship for Scotland, and in doing so to thank the Association for the consideration and kindness they had shown him during the nine years he had held that office. In quitting it he should leave behind him many happy recollections, so that he could not resign without feelings akin to regret; but he was sure that after so long a term of office the interests of the Association would be served by the infusion of new blood into the Scotch executive.

The PRESIDENT said that all present would hear Dr. Rutherford's intimation of resignation with regret (hear, hear). Before accepting his resignation it would be desirable to know who would be his successor, and as there happened to be no other Scotch member present but himself, it would be well to postpone consideration of the subject till a further meeting, if Dr. Rutherford would kindly hold on a little longer, which would be a great advantage to the Association.

Dr. RUTHERFORD said that under the circumstances he should be most happy to retain the office until a successor was appointed (hear, hear).

The PRESIDENT thereupon explained the mode of voting, and nominated Dr. Hetherington as scrutineer.

The lists having been collected, the scrutineer retired to examine them, and subsequently reported that the nominations of the Council had been unanimously supported, whereupon the following gentlemen were declared by the PRESIDENT to be duly elected as

OFFICERS AND OTHER MEMBERS OF COUNCIL OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

YEAR 1885-6.

PRESIDENT-ELECT	...	...	G. H. SAVAGE, M.D., F.R.C.P., London.
TREASURER	...	...	JOHN H. PAUL, M.D.
EDITORS OF JOURNAL...	{		
	D. HACK TUKE, M.D.		
	G. H. SAVAGE, M.D.		
AUDITORS	...	...	{
	H. F. HAYES NEWINGTON, M.R.C.P.		
	F. NEEDHAM, M.D.		
HONORARY SECRETARIES	{		
	E. M. COURTENAY, M.B. For Ireland.		
	J. RUTHERFORD, M.D. For Scotland.		
	H. RAYNER, M.D. General Secretary.		

MEMBERS OF COUNCIL.

J. A. CAMPBELL, M.D.	|	J. M. LINDSAY, M.D.
T. S. CLOUSTON, M.D.	|	CONOLLY NORMAN, M.D.

Dr. SAVAGE expressed his thanks to the Association for having elected him to be President, and said that he would do his best in that capacity.

The election of ordinary members was then proceeded with. The balloting box having been sent round, and there being no dissentient vote, the list was taken *en masse*, and the following gentlemen were declared to have been duly elected ordinary members, viz.:—W. C. Townsend, M.D., Visiting Physician, District Asylum, Cork; J. A. Oakshott, M.D., Assistant Medical Officer, District Asylum, Cork; G. V. Wilson, M.D., District Asylum, Cork; Lloyd Francis, M.A., M.D. Oxon., Assistant Medical Officer, St. Andrew's Hospital, Northampton; R. Percy Smith, M.D., M.R.C.P.B.S., Assistant Medical Officer, Bethlem Hospital, S.E.; T. Seymour Tuke, M.R.C.S., Manor House, Chiswick; G. Amsden, M.B. Edin., C.M., L.R.C.P., &c., County Asylum, Brentwood, Essex.

DR. HACK TUKE moved the election as an honorary member of Dr. Charles Nichols, the Medical Superintendent of the Bloomingdale Asylum, New York. That gentleman had for many years been well known in the United States as a most able superintendent and very efficient organizer and administrator. He was present at the last annual meeting, and the members had then had the pleasure of forming his acquaintance, both at the meeting itself and at the annual dinner. He (Dr. Tuke) had subsequently met Dr. Nichols in New York, and the high esteem in which he had previously held him had been strengthened by after-acquaintance. Dr. Nichols' election by the members of this Association would be gratifying to their colleagues in the United States, and add a distinguished name to their Association.

Dr. Woods seconded the motion, which was carried by acclamation.

The PRESIDENT brought under the consideration of the meeting the question as to the place of the next annual meeting, and it was resolved, on the motion of Dr. RUTHERFORD, that the next annual meeting should be held in London.

The next business being as to Committees,

The GENERAL SECRETARY said that the Parliamentary Committee had met frequently and done a good deal of work, and with the prospect of legislation in the coming year, it was a matter for consideration whether the Parliamentary Committee should be appointed as it stood.

Dr. Woods said he thought most decidedly that it would be better to keep the Parliamentary Committee in existence. So far as regarded England, there was no doubt there would be legislation before long; and as regarded Ireland, several Bills had been brought in, and all failed because there were no properly backed recommendations. He would propose that the Parliamentary Committee be re-elected.

The GENERAL SECRETARY having read the names of the members who last year constituted the Parliamentary Committee, viz., Dr. Lush, Dr. Blandford, Mr. G. W. Mould, Mr. H. Hayes Newington, Dr. William Wood, Dr. Savage, Dr. Clouston, Dr. Needham, Dr. Ringrose Atkins, Dr. Paul, Dr. Stocker, Mr. H. R. Ley, and Dr. Hack Tuke,

Dr. COURTENAY seconded the motion for the re-appointment of the Committee for another year, and proposed that Dr. Oscar Woods' name should be added to the list, which was agreed to.

With respect to the Statistical Committee, the opinion was expressed that the need for it had for the present ceased, and it was, therefore, agreed that it should not be re-appointed for this year.

The PRESIDENT announced that the adjudicators, consisting of Drs. Orange, Eames, and Rayner, had this year awarded the prize of £10 10s. (without a medal) to Dr. Greenlees, assistant medical officer at the Carlisle Asylum, for his essay on "A Contribution to the Study of Diseases of the Circulatory System in the Insane." (See Original Articles.)

The next business being to receive a recommendation from the Council in regard to the granting of certificates in "Psychological Medicine,"

Dr. HACK TUKE said it had been felt for some time past that some step might with advantage be taken by this Association in regard to granting some certificate of efficiency in psychological medicine. The College of Physicians

had had the subject of examination in this department brought before them again and again, but they had entirely declined to take up the subject. With respect to hygiene, the College of Physicians had adopted the simple plan of giving a certificate of efficiency in hygiene quite apart from the general diploma. It was proposed that a similar course should be pursued by this Association in regard to their own subjects of study and practice. He might observe that Sir Henry Pitman, the registrar of the College and an honorary member of the Association, was strongly of opinion that this proposal was a good one and would work well. The question was brought before the Council in February last, and a Committee was appointed to draw up a report on the subject, and to lay down what they would regard as the conditions and rules to be adopted. The report of the Committee was prepared and reported to the Council, who brought it before the quarterly meeting immediately afterwards, and in that report it was, as they would see, suggested that a special general meeting should be called to consider it, the step being an important one. When the matter was brought forward at the quarterly meeting it was unanimously decided to defer its consideration to the present meeting. This, of course, did away with the necessity for the proposed special general meeting. The report was as follows:—

Report of Committee appointed by the Council on Certificates in Psychological Medicine.

In accordance with the minute of the Council of the Medico-Psychological Association, held February 13th, 1885, we have considered the proposal to institute a certificate of competency in psychological medicine to be given to those willing to undergo examination under certain specified conditions, and have to report that we regard the proposal as not only a reasonable one, but that it is very desirable to take steps to carry it out.

For this purpose we propose that a general meeting of the Association should be called to receive the proposition, if the Council decides to adopt it.

We further suggest the following conditions and regulations relative to the examination:—

I. Candidates must be at least 25 years of age.

II.* They must produce a certificate of having resided in an asylum (affording sufficient opportunities for the study of mental disorders) for six months, or of having attended a course of lectures and the practice of an asylum where there is clinical teaching, for not less than three months.

III. They must be registered under the Medical Act (1858).

IV. The examination to be held twice a year, at such times as shall be most convenient, in London, Edinburgh, and Dublin.

V. The examination to be written and oral, including the actual examination of insane patients.

VI. The fee for the examination to be fixed at £5 5s., to be paid to the Treasurer, for any expenditure incurred, including the examiners' fee.

VII. Candidates failing in the examination to be allowed to present themselves again at the next and subsequent examinations, on payment of a fee of £3 3s.

VIII. The certificate awarded to successful candidates to be entitled "Certificate in Psychological Medicine of the Medico-Psychological Association of Great Britain and Ireland."

(The proposed form is appended.)

IX. Candidates intending to present themselves for examination to give 14 days' notice in writing to either the General Secretary of the Association, the Secretary for Scotland, or the Secretary for Ireland, according as he desires to be examined in London, Edinburgh, or Dublin.

* Subject to the final decision of the Council, as agreed.

X. The examiners shall be two in number for England and Wales, for Scotland, and for Ireland.

XI. They shall be appointed annually by the Council of the Association from members of the Association. They shall not hold office for more than two years in succession.

XII. Form of certificate to which the seal of the Association is to be attached:—

THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

Examination for the Certificate in Psychological Medicine.

This is to certify that Mr. _____ has satisfied the examiners as to his knowledge of the subjects of the examination.

Date.

Hon. Secretary.

Dr. HACK TUKE then moved on behalf of the Council that the foregoing report be adopted.

Dr. SAVAGE said he did not know whether it was quite in order that he should second the motion, but he would second it unless there was someone else present who wished to do so. He was distinctly of opinion that they ought to do something of the sort, and it seemed to him that if the present proposal were accepted and acted upon it would be done at a very appropriate time, and if future legislation took place it would be a very good thing for the Association to be able to say to whoever would be drawing up the next Bill: "We are distinctly prepared to examine men and to give some guarantee of their fitness for giving judgment in cases of lunacy." Although it might seem to be a very small beginning, and might take some time to develop, it was very likely to be a good thing in the end. It was certainly wanted, and he was not quite sure that the College of Physicians acted in opposition in any way. (Dr. HACK TUKE: "Not in the least.") One of that body, at all events, had said that he thought it a mistake to have a special examination in lunacy, and that lunacy should be part and parcel of what was expected in the qualification of a physician, not apart from it, but conjoined with it. This view was now carried out, but on a very small scale, examination papers always including one or two questions in lunacy. What was now proposed ought to be done, and he thought nobody could do it better than the Medico-Psychological Association. He hoped, therefore, that the report would be received and adopted.

Dr. RAYNER said he was most anxious that the proposal should be carried out. It would be of great advantage both to the public and to medical men who had paid attention to lunacy, and would lead to good in various ways. He would take the present opportunity of remarking, from a secretarial point of view, that if the proposal were carried it would be necessary at once to appoint examiners for England, Ireland, and Scotland. It would also be necessary that some steps should be taken by which the examination and the grant of the diploma should be brought to the knowledge of the profession generally, so that those gentlemen who were paying any attention to lunacy should know that it was possible to get a special certificate, and those who had special use for that certificate should know of its existence, and be encouraged to come forward and obtain it. He would suggest that, for some time, at all events, there should be in each number of the Journal some definite statement in regard to the certificate.

Dr. CONOLLY NORMAN said that the educating bodies should be communicated with, so that students at the medical classes should have a chance of knowing what was being done.

The PRESIDENT suggested that it might be advertised in the "British Medical Journal."

Dr. RAYNER said that the purpose would be answered if all the medical

superintendents would keep the knowledge of the diploma before the medical men who came before them, classes being informed, and so forth.

Dr. WOODS said he did not rise to oppose the proposal, but it was a very important point, and would take some years before it would come into general operation, and he thought it very questionable whether the second paragraph of the suggested conditions would be a desirable one to adopt as it stood, viz., that candidates must produce a certificate of having resided in an asylum (affording sufficient opportunities for the study of mental disorders) for six months. He took it that the majority of men trying for the certificate would not be students, but men of some standing in the profession, who were anxious to get some position in lunacy in order that they might be eligible to give evidence in trials and opinions in cases, and he thought that if the condition he had quoted were made a hard and fast rule a great many men would find it almost impossible to go in for the examinations.

Dr. RUTHERFORD supported the report, but thought that six months was rather long to fix for residence in an asylum. He suggested it should be altered to three months, which was the term for which clinical clerks were usually taken.

Dr. SAVAGE said that the term of office at Bethlem Hospital was for six months.

Dr. RUTHERFORD said three months' residence as a clinical clerk would be quite equal to a course of lectures on the practice of an asylum. Nearly twenty years ago Professor Laycock had a class extending over three months. At the end of the session an examination was held for a diploma, recipients of which were entitled to call themselves certificated students in mental disease of the University of Edinburgh. That fell into disuse after a time.

The PRESIDENT said he thoroughly agreed with the proposal contained in the report, which was an excellent one. He concurred with Drs. Woods and Rutherford that six months' residence in an asylum was rather long, because the matter would be somewhat of an outside one, and they could not expect to get many men to devote so much time and money to comply with that requirement. What ought to be done would be to make the study of mental disease compulsory, but that had been tried, and failed, although in Ireland they had succeeded with one University. This he would further deal with in his Address. He thought that in any lunacy appointments young gentlemen holding a certificate from the Medico-Psychological Association should have the preference over those who had not made mental science a special study.

Dr. WOODS said he merely wished to raise the question. He thought Clause 2 might be omitted.

The PRESIDENT said a man must show that he had a knowledge of an asylum in some way.

Dr. WOODS said that many medical men living in Cork might be willing to go in for the proposed examination if they could qualify themselves by a certain number of visits to an asylum.

Dr. RAYNER pointed out that the clause would meet this.

Dr. WOODS suggested that the word "residence" should be struck out.

Dr. HACK TUKE said that the clause gave the alternative "of having attended a course of lectures and the practice of an asylum where there is clinical teaching for not less than three months."

The PRESIDENT remarked that the proposal would be of more extensive operation if the alternative were allowed of having attended at any asylum. As the clause stood no man in Ireland could comply with it unless he lived in Cork, Dublin, or Belfast. In some asylums there was no accommodation for clinical teaching. Perhaps attendance at any asylum might be substituted in place of "residence."

Dr. WOODS said the way would be to strike out at any rate the words "where there is clinical teaching."

Dr. RUTHERFORD said that they had before them a recommendation from

the Council which had, no doubt, been well considered, and he felt that they ought to think well before they interfered with the decision of the Council. He thought, however, that some distinction should be made between simply walking round the wards of an asylum and actual residence or lectures with genuine instruction. He would suggest that the report, as a whole, should be adopted, but that it be remitted to the Council with the suggestion that Clause 2 should provide for three months' residence as a clinical clerk, or six months' attendance on the practice of an asylum, or three months' lectures with clinical instruction.

The foregoing proposal was agreed to.

Dr. NORMAN referred to the suggestion in the report (as read) that the examinations should be held on the last Fridays in January and July, and asked why those particular times were fixed upon. The July examination would very likely debar the examiners from attending the annual meeting of this Association or that of the British Medical Association.

Dr. HACK TUKE said that the time referred to was mentioned because it was just the close of the lectures in London; but perhaps that point had better be left open, leaving it to the Council to decide the days of examination from time to time as should be most convenient.

This having been agreed to, it was put to the meeting by the PRESIDENT that the report of the Committee should be adopted, with the foregoing amendment in Clause 4, and it was resolved accordingly.

It was further resolved that the examiners for the ensuing year should be—

For England—Dr. Savage and Dr. Hack Tuke.

For Ireland—Dr. Norman and Dr. Eames.

For Scotland—Dr. Howden and Dr. Ireland.

Dr. RAYNER said that during the past year he had received and referred to the Council a communication respecting a legacy of some £6,000 or £7,000 which had been left by a former patient in a private asylum, and the interest on which was directed to be applied to the relief of attendants in private asylums who had become incapacitated from work by sickness or age. In the communication referred to it was asked by the lawyer who had the management of the property whether the Medico-Psychological Association would be willing to undertake its application. The Council agreed that the work was of a nature which might well be undertaken by the Association, and this answer was communicated to the lawyer, but up to the present time no further communication had been received on the subject. He thought that the annual meeting ought not to pass without the members being made aware of what was probably coming.

Dr. EAMES enquired whether the legacy was confined to English asylums.

Dr. RAYNER said he believed it was for Great Britain.

Dr. HACK TUKE read a paper on "A Case of Moral Insanity." (See Clinical Notes and Cases.)

The PRESIDENT said he felt sure that the members would wish to thank Dr. Hack Tuke for his very able and interesting paper. It was well known to all gentlemen connected with asylums or who had studied mental disease that such cases, although not common, were to be met with. He had himself met with cases not quite so well marked as Dr. Tuke had mentioned, but corresponding to a great degree.

Dr. RAYNER said they were very much indebted to Dr. Hack Tuke for giving them such a case, which he thought might fairly serve as a type of this form of insanity. He did not think he had ever heard or known of any case which was so thoroughly typical of the particular state of mind which might be described by the term moral insanity or imbecility. He thought they should recognise that this, like all other phases and forms of insanity, might be a persistent state, persisting throughout the whole lifetime, but it might also exist in the development of any case of insanity, in some, perhaps, simply

being a momentary, unobserved phase, perhaps for only twenty-four hours, perhaps for longer. In senile insanity, especially, one often saw a state of moral imbecility, so to speak, persisting sometimes for even weeks or months, causing great trouble to friends. The earlier mental stages of general paralysis might almost be called states of moral insanity. Of course the question arose whether the acts of these moral lunatics were to be regarded as vices to be punished or as an abnormality to be treated, and whether the punishment or the treatment was the better thing. One astonishing thing was the utter loss of self-control. The individual was apparently unable to see the relation of anything but in so far as the fact before him was pleasant or disagreeable. The results he utterly ignored, accepting the immediate thing before him regardless of future consequences. That loss of self-control, being persistent throughout a life, certainly should not subject the individual to the ordinary modes of punishment. He should be treated, but whether he should be treated by being deprived of education, as Dr. Kerlin suggested, he (Dr. Rayner) would be inclined to doubt. He thought that they would have the greatest chance of establishing self-control by developing as many of the faculties as possible. To do this in a case such as that under consideration, when it had become a chronic or life-long case, would be very difficult indeed, but it was a question whether, if the patient had been taken in early life, something might not have been done. It appeared that this man was educated in the advantages of moral insanity. He was recognised as being morally insane, and escaped treatment. He had throughout his life an education in moral insanity, which might, perhaps, have been less developed had he been appropriately treated from the onset.

Sir CHARLES A. CAMERON, President of the Royal College of Surgeons, Ireland, said that the case which had so graphically been described by Dr. Tuke was one of great psychological interest. It proved that the most cruel elements of man's nature could be co-existent with a fair amount of intellectuality, but still might be practically uncontrollable, owing to the almost, if not altogether, complete absence of moral attributes. This hideous creature delighted in acts of cruelty; the sufferings of sentient beings were to him a real pleasure, and the intense desire to gratify it led him to commit crimes which he was intellectual enough to know would, if detected, bring punishment down upon him. Many savage races enjoyed an exquisite pleasure in practising cruelties, and our early ancestors were not insensible to this horrible source of enjoyment. Even at the present time children are frequently observed to take delight in torturing animals. Plucking legs from flies, throwing stones at dogs, cats and birds, are favourite practices with the young, though under the influence of education, religion, example, and public opinion, cruel schoolboys grow up to be kind and tender-hearted men. Dr. Tuke's case might be regarded as one of moral atavism, —the reproduction of a ferocious, savage ancestor. The term moral imbecility applied to this case seemed to be the best that could be used. It was an exaggerated instance of an utterly debased moral nature, with an instinctive love of cruelty, such as is found amongst many of the carnivores, who kill even when they do not desire to devour their prey. No doubt many of those criminals, who, like Tropmann, appear to have had no adequate motive to induce them to commit their cruel and murderous deeds, were as morally imbecile as Dr. Tuke's case. As crafty and cruel as the tiger, they are equally devoid of moral attributes. Perhaps it would be as reasonable to blame the tiger or the wolf for their ferocious disposition as to hold responsible for their want of morality men such as that described by Dr. Tuke. One thing seems certain, that we should treat them as we would a dangerous animal—not unkindly—but in such a way as to prevent them from indulging their malignant propensities.

Dr. NUGENT said he had met with cases which, taken numerically together, represented the several characteristics of the case quoted by Dr. Haack Tuke, but he had never met with those characteristics all concentrated in any one case. He questioned whether the term "moral insanity" was strictly applic-

able to it, but rather moral imbecility, the case having commenced with infancy and continued, as described by Dr. Tuke, up to the very moment of his being punished for six months. It was a most interesting case. He was inclined to think that the man had never exercised his intellect, or that he did not understand or give himself time to consider whether his guilty actions were crimes or not. It was an unaccountable impulse which induced him so persistently to adopt the course of life he did. He (Dr. Nugent) had known persons who were naturally of a cruel temperament though very kind at times, and individuals of that temperament continued generally thus through life, although they might be altered or improved. The important question for consideration was whether the man referred to was a criminal or not. He did not think he was a criminal. He thought that nature had implanted in him a disposition that nobody could regulate besides himself. What was the duty of society? To come in and protect him as far as possible from the results of his own actions, and at the same time to protect society from the results of his bad conduct. Was a prison or a lunatic asylum the best locality for a man of that temperament? He (Dr. Nugent) conscientiously thought, under the circumstances, that the man, being more or less an irresponsible person, a lunatic asylum would be the best place for him. There he would be carefully watched, and, if any prospect of improvement should appear, that improvement could be very much better carried out at a lunatic asylum, under men conversant with mental disease in all its forms, than in a prison, where the result of his association with prisoners would be to make him and them worse. The important point, therefore, in this case was as to treatment.

Dr. SAVAGE said he concurred with Dr. Rayner that Dr. Hack Tuke's case must form the classical case to which all reference in future should be made. It was complete as far as it went, but it would have been a good thing if they could have learnt more of the personal characteristics. As regards his own experience, he mentioned the case of a young fellow who from birth had been addicted to lasciviousness, having at four years of age been guilty of indecent liberties with children of the other sex, and at six years of age been bad with maid-servants. At the same time he had exhibited considerable power on the lines commonly associated with moral imbecility. He had a wonderful memory for isolated facts, so that when he was examined at the court he corrected the witnesses in the most glib way by saying, "You are wrong; it was two o'clock on such and such a day," or correcting them in regard to similar matters of perfect indifference, but showing extraordinary memory. He was a fair musician. His skill and cuteness were such that the special jury enquiring into his case found that he was of sound mind. He was then twenty-seven years of age. He was afterwards found guilty of an indecent offence, and sent to gaol, and had lately after his discharge been behaving sufficiently well to be at large and control his affairs after a fashion. Here was a case begun very early in life, getting worse in adolescence, and finally becoming so bad that society, frightened, thrust him aside when he was a man; and yet that person had been well enough to be at large for two years. How far should punishment be made use of in such a case? He agreed with Dr. Nugent in regard to this. As to love of blood, he had seen several cases. That which he would make special reference to would fall in with what Dr. Rayner referred to as to cases passing through a stage of moral loss of control in the development of acute mania. The case he quoted was a most talented musician, a man looked upon as the tenor of the future. Unfortunately there was insanity in the family. He went to an abattoir and ordered a pint of fresh blood, which he drank off at one draught. He went again, but by that time they had got suspicious. His thirst for blood was so great that he would almost certainly have murdered a child to get a drink of blood. While referring to this case he would like to say a word on an allied condition. There were other impulses which most people who were not moral

imbeciles or morally insano would recognise in themselves to a certain extent, and in their friends to a greater extent—the tendency of not liking to look down from a height or a feeling of throwing one's self before a train. These impulses were all connected. He saw a child whose mother was in Bethlem immediately after his birth. The child was brought to see him under these circumstances: a very little work, reading or writing, or that sort of thing, caused pain at the top of the head, and it was a question whether he should be treated in the way described by Dr. Kerlin. Education was given up for a time, and on enquiry from the little lad himself it appeared that the two dreads of his life were heights and railway trains, and he could not go back far enough to tell me when those dreads came on. It had so grown that the very sight of a ladder caused the lad to catch hold of anyone with whom he was walking. He would conclude by merely observing that this was an interesting addition to the symptoms of moral insanity.

The PRESIDENT said that as the time at their disposal had expired it would be necessary to postpone the further discussion of Dr. Hack Tuke's interesting paper till the afternoon.

The members then proceeded, at the invitation of the President, to the Cork District Lunatic Asylum, where they inspected several of the interior arrangements, and more especially the very complete system of Turkish baths. The asylum accommodates 1,030 patients, the average number resident during the year 1884 being 903, and had formed the subject of very favourable reports from the inspectors, who had made five visits during the year. The members of the Association inspected the "Eames Asylum Locks," with which the doors of the asylum have been fitted throughout, and which were explained by Dr. Eames to possess four distinct actions, and to claim many advantages.*

AFTERNOON MEETING.

The PRESIDENT read his Address, which will be found at page 215 of this Journal. (Original Articles, No. 1.)

Dr. RUTHERFORD moved a vote of thanks to the President, saying that the Association had much to thank him for—for his excellent Address, for his conduct in the chair, and last, though not least, for kind hospitality that day received at his hands. He was only sorry that so few of their brethren from England and Scotland were present, but for them he felt sure he might speak. This meeting at Cork would be long remembered as one of the most sociable and pleasant meetings ever held by the Association. Dr. Eames had introduced some interesting subjects into his Address. In regard to the system of bathing which he had recommended, history repeated itself. He (the speaker) remembered that some twenty years ago, when he stayed some time at Hayward's Heath Asylum, he saw an excellent Turkish bath there in active operation. He did not know whether it was still in use. In 1867, when he went to Argyle Asylum, he found one there which was used every week. Dr. Sibbold, his predecessor, was much in favour of bathing. He did not know whether it was in operation now. He was afraid it had fallen completely into disuse. He thought it a most excellent mode of treatment. As to the question of assistants, there was no doubt that every asylum ought to have an assistant medical officer. He might go further, and say that every asylum with four hundred patients or more ought to have two assistants. He had had experience of one assistant and of two, and he must say that where there were four hundred patients it was of great advantage to have two assistants. Things went on more pleasantly, and the assistants had quite enough to do if each had one side of the asylum. Then as to attendants—their residing in houses on the estate and entering into service with a view to pension—he must say that his experience did not lead him to those conclusions. There were attendants and attendants. Occasionally there would be a very good attendant, whom one

* See Notes and News.

would like to keep as long as he would remain; but he found that the majority of attendants were men who got lazy, and deteriorated. He did not know whether there was a deteriorating influence about asylums, but he found that after four or five years' service it was as well to change attendants. The best years of service were the third and fourth years, and after that it was as well to get rid of them. Then, too, he thought that unmarried attendants, coming only for a short time, four or five years, were preferable. The wages of ordinary attendants over England and Scotland were not sufficient for a man to keep a wife and family. For three or four years he had not engaged a married attendant, saying, "No; the wage we offer, £30 per annum, is sufficient for a single man—handsome for a single man—but not sufficient for a married man." Any attendant wishing to marry had to resign his appointment. He made it a rule that no man under him was allowed to marry unless he had at least a pound a week. He thought, for their own happiness, this was desirable. As regards instruction in mental disease, there could be no doubt of its importance. The medical profession were the only body of men of whom any two could deprive a man of his liberty, and yet the men who might do that might have had no special instruction. He felt sure that that was a most important point, with which the members would agree.

Dr. MACLEOD seconded the vote of thanks, saying that he had listened to the Address with very great pleasure, and regretted that time did not permit them to engage in much discussion upon the several interesting points involved in it. In regard to attendants, he had a very great objection to married attendants living inside. They generally had a number of small children, and the children were constantly catching some children's complaint, such as scarlet fever, measles, and whooping cough, and were a very great bother to the asylum generally. Otherwise they occasionally met with a man who was a good servant and good attendant for many years; but, as far as his own experience went, he should very much endorse what Dr. Rutherford had said in regard to attendants deteriorating after a few years.

The motion was then put to the meeting by Dr. RAYNER, and carried with applause.

The PRESIDENT thanked the Association for the vote of thanks. He regretted that the time remaining at their disposal was too short to admit of his further answering the remarks of the speakers. He might say, with respect to the question of married attendants, that he quite agreed with Dr. Macleod, but the difficulty referred to by that gentleman might be avoided by cottages being built in the vicinity of the asylum.

Dr. RAYNER said that in this connection he should like to mention that a few years since the Committee of the Hanwell Asylum adopted the plan of allowing the married attendants lodging money, so that they might live out if they wished, and the change had been a most beneficial one in constituting a very well-conducted class of attendants. He thought he must differ to some extent from Dr. Rutherford in regard to the deterioration of attendants. That depended on the time at which the attendants were first taken for asylum service. If a man began service rather late in life, he thought Dr. Rutherford's observation would hold good, and that after three or four years, when the first interest in the work had gone off, there would be deterioration. There was often great trouble in training a very young attendant, but if they succeeded in doing so, the probability was that he would remain a good attendant all through. His own best men were those who had begun quite early, but had been trained satisfactorily, and remained satisfactory, and he hoped they would remain so for some time to come.

The discussion on Dr. Tuke's paper was then resumed, but time did not allow of many remarks.

The President having called on Dr. TUKE to reply, the latter said he was indebted to the members present for the way in which they had received and

discussed his paper. He would only say further that he fully agreed with Dr. Nugent in laying stress on the constitutional moral defect in this case, and which therefore made the term "insanity" less fitting than imbecility.

On the motion of Dr. CONOLLY NORMAN, a vote of thanks was unanimously accorded to the authorities of Queen's College for the use of the room, and the proceedings then terminated.

LOCKS FOR DOORS IN ASYLUMS.

During the visit made by the Medico-Psychological Association to the Cork District Asylum Dr. Eames took the opportunity of showing the members the "Eames Asylum Locks," with which the asylum was fitted. The locks possessed four distinct actions, and claimed the following advantages:—

1st.—The ordinary attendant's key turns the bolt once, opening the door, and, when the bolt is freed and the door opened, the bolt, on taking the key out, instead of keeping back springs forward and remains flush with the door, which cannot be shut without inserting the key and giving it a turn back. This prevents a patient from locking an attendant or himself in a cell.

2nd.—It prevents the slamming of doors, a most frequent and objectionable practice in Lunatic Asylums, as the key must be inserted again, when closing the door, to lock it.

3rd.—The bolt is turned a second time by another key, which is supplied only to the head attendant of a division and the night attendant; the object of this is, that when the patients are given over for the night to the night attendant he, in passing through, gives the second turn, driving the bolt still further in, thus preventing access to the patients by the day attendant, whose key cannot then turn the bolt back, and thereby fixing the responsibility of correct inspection and safe custody for the night with the officer on duty. In his (the night attendant's) first round afterwards, when all day attendants are in bed, he takes the second action off each lock. To anyone acquainted with the details of asylum discipline this will seem to be a most important arrangement.

4th.—The bolt of all locks leading to exterior of buildings, or from male to female divisions, or any other place thought necessary, is turned a third time by a master key, and cannot be unlocked by any other. The necessity for this action is obvious. The master key is only supplied to officers of the institution.

Thus each of the three keys will open the door by one turn; the second key gives a second turn, and the third key a third turn, the bolt being at each turn driven farther into the door plate.

Dr. Eames further pointed out another most important advantage in the locks, viz., that the face of the lock has a depression around the bolt which fits into a corresponding elevation on the striking plate, thus preventing the possibility of the bolt being shot by a knife, handle of a spoon, or by any other means.

The interior of the lock is made entirely of gun-metal, of the best and simplest workmanship. The striking-plate and face of lock are brass. The keys are very strong and made of case-hardened steel, and are constructed so as to render it impossible for one to be converted into another, i.e., a first-action key could not be made into a second, or either of them into a master key. The makers are Young and Glover, Bell Street, Wolverhampton.

BRITISH MEDICAL ASSOCIATION.—ANNUAL MEETING, CARDIFF,

Wednesday, 29th July, 1885.

(SECTION E.—PSYCHOLOGY.)

President: D. Yellowlees, M.D., Glasgow. Vice-Presidents: C. J. Hearder, M.D., Carmarthen; G. E. Shuttleworth, M.D., Lancaster. Secretaries: C. Pegge, M.R.C.S., Vernon House, Briton Ferry, Glamorgan; A. Strange, M.D., County Asylum, Bicton Heath, Shrewsbury.

The admirable address by Dr. Yellowlees, which has appeared in the "British Medical Journal," will have been read with pleasure and profit by all engaged in medical practice, and its exhortations are so practical that we hope the author will procure for it the wider circulation which a separate publication can alone ensure. It should be read by laymen at least as largely as by the members of the medical profession.

Dr. Campbell's paper on the "Treatment of Maniacal Excitement" has already appeared in the "Lancet" (Aug. 8th, 1885). We, therefore, shall not reproduce it here, and it does not admit of condensation. In the discussion which ensued, the following remarks were offered:—

Dr. HACK TUKE would have been glad to hear Dr. Campbell's experience in cases of acute delirious mania. The treatment he had recommended for acute mania—exercise in the open air—would certainly not be applicable in the cases referred to, where there was so much exhaustion. He thought that whether there was an actual change in the type of mental disease or not, mania assumed in general a milder character now than formerly. More judicious treatment, it might be said, accounted for this, but could it explain the apparent increase in general paralysis? He was very glad Dr. Campbell had insisted on the out-of-door treatment of mania, not of the exhaustive type. It would be read in America with interest, and would help to introduce there that mode of treatment.

Dr. MACLEOD thought much of the difficulty in the treatment of insanity depended on the want of a proper classification. Mania was no more a disease than dropsy; excitement might occur in the course of other diseases, such as Bright's disease—delirium from uræmia being often taken for maniacal excitement; the treatment for the renal disease being applied, the excitement subsides. The continual use of sedatives is really hurtful. Hypnotics (of which paraldehyde seemed the best) in single doses at night, especially combined with suitable stimulants, were most useful. In cases of asthenic excitement, rest and food were essential. Proper use of seclusion was most beneficial.

Dr. POWELL said that he often felt at a loss what course to pursue as to the use of sedatives in excitement. To discard them altogether is certainly unwise. He referred to the treatment of insanity by means of coloured glass; it had at first seemed useful, but not in the end.

Dr. BONVILLE FOX spoke of the great use of the hot bath, at a temperature of 110° to 120°, in cases of maniacal excitement. He maintained that it was preferable as a sedative to bromide or chloral, for it does no harm if it fail to act, whilst drugs often fail and do harm as well.

Dr. NORMAN, anent Dr. Campbell's mention of congestion of the lungs in a patient long treated with bromide, drew the attention of the meeting to the fact that low pneumonia had been described by Hammond of New York as a result of chronic bromism. A case pointing to the same conclusion had been recorded in the West Riding reports.

Dr. MICKLE did not believe it was possible there could be any change in the type of disease in so short a time as thirty or forty years. He thought the relative influence of different sedatives had been already decided by previous observers.

Dr. WOOD did not think well of the bromides.

Dr. STRANGE did not think there had been any change in the type of disease, nor did he share the contempt at present prevalent for sedatives and seclusion. He had seen good results from bromide and chloral carefully given.

The discussion was adjourned till the next meeting of the Section.

Thursday, July 30th.

The discussion on the treatment of maniacal excitement, which had been introduced by Dr. Campbell's paper, was resumed.

The PRESIDENT congratulated himself on having suggested a subject which had produced so valuable a paper and so good a discussion. He thought the idea that excitement must always be repressed at whatever cost a great mistake, and one that had done much harm. The ebullition of excitement might be really the best thing for the patient, if it could only be so guided that it did not result in injury to himself or others. When superfluous brain-energy expended itself in vigorous bodily exercise, whether in walking or working, it was its best and safest outlet, provided always that the enormous waste was made good by very liberal support. He had come to regard purely sedative and anti-excitement drugs as palliative rather than curative, and as sometimes hindering the cure rather than furthering it. Therefore he preferred to obtain calmness and sleep by other means if possible. He agreed in thinking warm baths very serviceable, and had frequently seen yet greater benefit from the wet pack when wisely used. He warned against the risk of hot baths with cold to the head when such extremes of temperature were too prolonged. He had seen a sudden death under such circumstances from failure of the heart's action. As to the change in the character of maniacal excitement, he thought it beyond question that a marked change had occurred. No one would doubt this who could recall the furious, destructive, and utterly unreasoning excitement so familiar 25 or 30 years ago and so rarely seen now. In his experience maniacal excitement had become less violent, less incoherent, and more founded on what seemed to the patient sufficient grounds than in former days, while melancholia had certainly become more frequent. The cause of this change was a very difficult question. Perhaps some change in the national constitution had been making all diseases less sthenic than they used to be. Acute pneumonia, for example, had lost much of its former character, and would not bear the old treatment. Unquestionably improved surroundings and improved modes of treatment had much to do with the altered character of the excitement. Yet he believed they had been as careful and observant, as kindly and considerate, then as now, and he could not regard this as a complete explanation. He had recently questioned a very experienced head attendant on this subject, and the unhesitating reply was that the disease had quite changed from what it used to be. When asked whether the improvement was not due to a change in treatment rather than to a change in the disease, the reply, given after thoughtful consideration, was, "Partly both." This answer was probably correct.

Dr. PRINGLE agreed with previous speakers in preferring to treat maniacal excitement by exercise in the open air rather than by drugs, whenever this was possible. He spoke of the various ways of procuring sleep, and gave some interesting and valuable details of his personal experience in insomnia, from which he had formerly suffered. Fresh air and exercise, change and rest, a sea voyage, and all kinds of medical treatment—stimulating, depressing, narcotic, sedative, and electrical—had been tried in vain. Nothing had been of so much service as the simple expedient of placing the feet in ice-cold water for some minutes before getting into bed. This speedily determined reaction; the feet became burning hot, and the degree of brain anæmia necessary for sleep was apparently thus produced. He recommended this simple hypnotic for more general trial.

Dr. CAMPBELL briefly replied to the criticisms on his paper, and rejoiced that it had evoked such a discussion.

The PRESIDENT then called upon Dr. D. Hack Tuke to introduce the subject of Lunacy Legislation.

Dr. TUKE, in commencing his address, said that the Lunacy Bill before the late Government had fallen through in consequence of political events with which they were all familiar. The Government which was now in office, if not in power, had brought in a short Bill having sole reference to the detention of pauper lunatics in workhouses, but had engaged—so far, indeed, as a Government could do which might be neither in office nor power after November—to bring in a Bill next session. The question must come up again whichever party might happen to come into power, and for that reason he hoped that the discussion on Lunacy Legislation that day would not be a waste of time; and he might add that, although the Bill was deferred, the same motives were in force to legislate without due regard to the opinions of medical men. The practical question before them he took to be this: What ought we to strive for when a Bill is brought in next session whether we have regard to the interest of the patients or of medical men? Without restricting himself to them, he would mention the following as the main points which deserved consideration, and which he should consider in connection with the late Lunacy Bill:—1. The intervention of the magistrate. 2. The protection of the signers of medical certificates. 3. The interests of the proprietors of private asylums. 4. The protection of patients. 5. The protection of workhouse medical officers from improper interference with their just rights. He submitted, with regard to the first point, that while recognising magisterial action in private as well as pauper cases, stringent clauses should be introduced guarding medical men against improper interference on the part of the magistrate. With regard to the second point, it might be expected that a similar clause to that in the late amended Bill would be introduced, namely, that “a medical practitioner who signs a certificate according to the Act, with good faith, shall not be liable to any civil or criminal proceeding for signing the certificate, or for any act done with the view of enabling him to sign it.” This was excellent, but it would be well to try and have a still further check on vexatious actions, by adding that in any action taken against medical men *the defendant should be entitled to require that the plaintiff should give security for costs in the event of losing his action.* This he should ask the Section to adopt as a resolution. He had legal opinion for saying that there was precedent for such a proviso, which might and no doubt would be objected to on the ground that a poor man could not obtain redress although he had been wrongfully detained in an asylum. But that was no reason why the signer of a certificate or the superintendent of an asylum should be wrongfully mulcted to the extent of several hundred pounds by the proceedings of a person who was, as the verdict of the jury showed, rightly confined and mentally incapable of comprehending his legal position. Dr. Tuke considered that when a new Bill was introduced it was most important to see that the signers of certificates were not hampered by the restrictions in force, but should be allowed to examine an alleged lunatic precisely in the same way as any other patient, conjointly. With regard to the third point, he submitted that if justices of the peace were to provide accommodation for private patients, separate buildings and separate superintendence should be introduced; it was also a question whether registered hospitals might not receive State aid or local help rather than that pauper asylums should be employed for private patients. He approved of the provision in the late Bill that at the end of five years pauper patients should not be admitted into private asylums, but he thought there should be compensation. On the fourth head, he might point out that what had been already contended for was also done in the best interests of the patients. He would also say that it seemed very proper that private patients should be visited as soon as convenient after admission by the Commissioners or medical visitors, but in the former, or, indeed, any case, the number on the Lunacy Board should be increased. In regard to the last point, the protection of workhouse medical officers, Dr. Rogers would enter fully into it. He would only say that the wording of the clause in the

late Bill having reference to the signing of certificates by them was obscure, seeing that it was read differently by different people. There should be no ambiguity in the matter; it would be very unfair to deprive these officers of their just emoluments.

Dr. ROGERS (who spoke now because required in another section) said he had had a long experience of interviewing by magistrates, and disagreed with it. Such examinations should never take place in public, for it had a baneful influence. It was a difficult matter for unprofessional men to judge in these cases, for the most dangerous class of lunatics were what he called "the reasoning class." The late Bill grossly interfered with the present rights of workhouse medical officers, who number no less than 650, although it did not personally affect him, as his salary was not a fluctuating one. The medical man attached to a workhouse is the most suitable to sign a certificate for a pauper lunatic, and he ought to be paid for it.

The PRESIDENT then requested Dr. Campbell to read his paper on "Lunacy Legislation," that it might be debated at the same time as Dr. Tuke's paper.

Dr. CAMPBELL* read a short paper, giving a summary of his views on Lunacy Legislation. He pointed out defects in the present Lunacy Acts of both England and Scotland. He proposed that lunacy legislation similar in all but the details necessitated by laws of the countries should be applied to the three kingdoms. That two certificates should be needed for poor as well as rich people, as their liberty was of quite as much consequence to them. That an open inquiry should take place in Scotland as in England in questionable deaths. That there should be a legal mode of transferring patients under lunacy certificates from one county to another. Certain suggestions were made as to providing for accommodating private patients in public asylums, and the inconsistency of expecting the Visiting Commissioners to do such an increase of duty as has fallen to their lot was pointed out. In 1854, there were six Commissioners for visiting purposes, and 20,493 patients in public asylums; now there are still the six Commissioners and 54,624 patients in public asylums. In England each Commissioner has to look after 9,000 patients who are in public asylums, while in Scotland the two Commissioners have only 7,853 between them. The readjustment of the Commission is as clamant as anything in our lunacy system.

Dr. CONOLLY NORMAN said that in Ireland the certificates of two magistrates were required prior to the admission of a patient into an asylum. In the case of paupers, a police doctor was called to their assistance. The lunatic was arrested by the police under a warrant, which was a poor beginning for his treatment, and they retain, as is natural, a hatred against their friends who brought all this about.

Dr. STEWART dwelt on the unsatisfactory state of the lunacy law in Ireland. Patients are often conveyed to an asylum between policemen on a jaunty car, and are treated like criminal lunatics.

Dr. PATTEN spoke to the same effect.

Dr. POWELL stated that the magistrates in Nottingham go to see the patient in his house, and heard the story the friends had to tell, and examined the alleged lunatic. This was much better than taking him to the police-court.

Dr. MICKLE considered that one defect in the late Bill was that it altogether failed to protect superintendents as well as the signers of certificates. He objected to justices being called upon to provide accommodation for private patients. He believed the payments of private patients would not make such an undertaking profitable. As to the removal of pauper patients from private houses, he did not credit the probability of obtaining compensation. It had

* Dr. Campbell's paper was not received in time for publication. For the above notes of it we are indebted to Dr. A. Henry, sub-editor of the "British Medical Journal."

been said, why not fill up the vacancies caused by the removal of paupers by low-class paying patients? He did not believe anything like a sufficient number would be obtained to make up the loss.

Dr. NEEDHAM thought that the intervention of the magistrate must be accepted as a fact. The thing was to guard his action. He disapproved of pauper asylums being used for private patients.

Dr. BONVILLE FOX, speaking on behalf of private asylums, said he thought the case against them had not been made out. As a matter of self-interest, those who kept them would discharge their patients as soon as possible. As a matter of fact, patients were kept in private asylums a shorter time than they were in public institutions.

Dr. SHUTTLEWORTH dwelt on the necessity of re-introducing into any fresh Bill the clauses the Lord Chancellor was willing to introduce, rendering it unnecessary to have the same certificates for idiots as for the insane.

The PRESIDENT said that in Scotland the provision in regard to the Sheriff's intervention applied alike to private and pauper patients. The endorsement of the Sheriff was a wise arrangement, and he had always deemed it a judicial act. The personal examination of the patient by the Sheriff was almost unknown. They could not understand in Scotland the objection which their friends in England had to the action of the magistrate. In Scotland the propriety of the Sheriff's intervention ere a patient could be placed in an asylum was universally approved. It satisfied the public, for it was deemed conclusive as to the legality of the course adopted, and it practically protected the doctors who signed the certificates for, so far as he knew—and he believed he could speak absolutely—no legal action had ever been taken against the certifiers when the Sheriff had endorsed their certificates by granting an order founded on them. He thought that placing a patient in an asylum involved two separate things—first, that he was insane, and secondly that his insanity was of such a character as to render him, as the Sheriff's order phrases it, "a proper person to be detained and taken care of." The patient's mental condition was purely a medical question, but the deprivation of personal liberty is surely as much a legal as a medical one, and should have legal sanction. All the talk about the Sheriff or magistrate overriding medical opinion he deemed of no moment, as it arose merely from professional over-sensitiveness and from ignorance of the practical working of the principle elsewhere. As to private asylums, he was not aware that they had done anything to deserve abolition, and he thought there would always be room for a few of the best of them. He did not see how public provision could be made for low-class private patients except by annexes to the county asylums. The experience of the Scotch Royal Asylums amply proved that there was no difficulty, and even some advantage, in treating pauper and private patients in the same institution. He thought that the English lunatic hospitals might do vast good by lowering their charges and receiving larger numbers of lower-class patients. They were most admirable institutions, but it might be questioned whether their tendency was not to become luxurious retreats for a few fortunate patients rather than the great public charities they might be made.

Time not allowing of the consideration of the resolution which Dr. TUKE had brought forward in regard to actions against medical men, the meeting adjourned.

Friday, July 31st.

The discussion on Lunacy Legislation was resumed, Dr. TUKE moving his resolution in regard to actions against medical men.

Dr. WOOD, in seconding it, entered at some length on the general question, having been prevented attending on the previous day. He strongly objected to the intervention of the magistrate in any case, and he had never heard that the

Scotch approved of the action of the Sheriff. As to private asylums, no case had ever been made out against them. They had triumphantly passed through the ordeal of the Select Committee of the House of Commons.

Dr. MICKLE wished the resolution to comprise medical superintendents as well as the signers of certificates.

Dr. CAMPBELL opposed it, as contrary to the fundamental principles of Roman and Scotch law.

Dr. NORMAN spoke in its support, as did several others, and it was carried with the amendment of Dr. Mickle, who was requested to bring it under the notice of the Parliamentary Committee of the British Medical Association.

The PRESIDENT referred to what had fallen from Dr. Wood in regard to the action of the Scotch Sheriff, and repeated his opinion in its favour. He said it was the great safeguard against discharged lunatics bringing actions against medical men, and that, instead of resenting it, the profession should welcome the endorsement of their certification by a legal functionary. The suggestion that, in order to avoid the appearance of magisterial revision of medical opinion, the magistrate should be summoned to the lunatic before the doctors certified, he characterized as a grotesque inversion of their respective positions, for a magistrate could, and should, decide as to a lunatic's condition and his need of asylum care only on formal and definite medical evidence.

Dr. MICKLE then read his paper on "Brain-disease of Traumatic Origin." (See "Clinical Cases.")

Dr. SHUTTLEWORTH asked Dr. Mickle whether in either of the two interesting cases brought forward, hereditary tendency to insanity existed. In his experience with regard to idiots, injuries to the head from falls, &c., was an assigned cause of idiocy in no less than six per cent. of his admissions; but he believed that in these cases heredity was a very important factor—falls on the head in infancy being extremely common without any mental impairment.

The PRESIDENT said he had certainly known general paralysis to follow injury to the head, and although Dr. Mickle did not call two of these cases by that name, he would like to know if he did not so regard them. [Dr. MICKLE replied affirmatively.] He had been surprised at the amount of injury the brain could endure without interference with its functions. Many illustrations of this had been recorded, and he cited two from his own experience. One patient struck another on the head with a spade, inflicting a gash through the skull about five and a half inches in length, yet the effect of the concussion quickly passed off, and the wounded man remained conscious, intelligent, and unparalysed for more than 24 hours after the injury, when fatal coma gradually supervened. In the other case the patient stood before a looking-glass and with a pointed coal hammer inflicted repeated blows on his forehead. There were several punctate fractures, as he could not always strike the same spot, but at the central spot, where most of the blows fell, there was a hole through the bone into the brain. The man neither fell down nor lost consciousness. Several very severe epileptic seizures occurred after he went to bed, but they ceased as soon as some sharp fragments of bone, which had evidently been sticking into the brain, were withdrawn. There was much bleeding, and brain fluid and fragments of brain substance subsequently escaped from the wound. This patient never had a bad symptom. Within a month he was walking about, and in another month was discharged and sent home to his friends. He thought friends were always prone to assign head-injury as the cause of the insanity, as it seemed to remove the suspicion of any family predisposition.

"The Results of Marriages of Consanguinity" and "Suicidal Insanity" were the other subjects included in the programme, but there was no time to enter on their discussion.

The interesting and successful meetings of the Section were brought to a close by a cordial vote of thanks to the President and office-bearers.

CONGRESS OF PSYCHIATRY AND NEURO-PATHOLOGY.

The Congress which met at the Hôtel de Ville, Antwerp, Sept. 7th, 1885, was initiated by the *Société de Médecine Mentale de Belgique*, of which it formed, in fact, a "Réunion extraordinaire." M. Oudart, the Inspector-General of Asylums in Belgium, was the Honorary President, the actual President being Dr. Desguin of Antwerp; President, Dr. Lentz (Tournai); Secretary, Dr. Ingels (Ghent); Assistant-Secretaries, Dr. Cuyllits (Brussels), and Dr. Jul. Morel (Ghent). The organizing Committee consisted of Drs. Heger, Lefebvre, Semal, and Vermeulen. Among the Honorary Presidents were Dr. Christian (France); Dr. Brosins (Germany); Dr. Benedict (Austria); Dr. Mierzejewski (Russia); Dr. Hack Tuke (England); Dr. Rutherford (Scotland); Dr. Eames (Ireland); Dr. Ramaer (Holland); Dr. Steenberg (Denmark); Dr. Sola (Argentine Republic).

The number who gave their adhesion to the Congress amounted to 180, but the number actually present did not exceed 70. The members were invited to assemble on the evening preceding the meeting at the hospitable house of the President, M. Desguin, who, throughout the Congress, presided over its deliberations with admirable fairness and courtesy.

On the first day of the Congress the members were received by the Burgomaster of Antwerp at the Hôtel de Ville, to whose welcome M. Desguin made a suitable response on behalf of the members. The address of the President opened the proceedings of the meeting. It was followed by communications, from many members, present or absent, including MM. Foville, Oudart, Benedict, Brosins, &c. They did not lead to much discussion. The paper by Brosins however, "On the Use of Alcohol in the Treatment of the Insane," elicited considerable remark.

The morning meeting of the second day of the Congress was devoted to the discussion of a paper by Dr. Lefebvre "On the necessity of International Statistics of the Insane being made on a common base." This led to an important debate, the practical result of which was the decision to appoint an international commission on the subject. Various papers of interest were read in the afternoon, including those of Drs. Christian, Lentz, Marique, and Ingels. Dr. Verriest, Professor in the University of Louvain, exhibited a case of somnambulism, a woman who passes through three stages of existence, and is alleged to live three distinct lives, the consciousness of each being separate from that of the others.

On the last day of the Congress, an animated debate took place on a communication made by Dr. Semal, of the Mons Asylum, on the relations between crime and insanity. Dr. Benedict contributed an able paper to the discussion, which was warmly received. A very interesting debate ended in the adoption of a few practical propositions which, it is to be hoped, will materially forward criminal research in prisons by competent men in every country.

A banquet closed the proceedings of a very successful Congress. Excursions were, however, made on subsequent days to Gheel, Mons, Tournai, &c.

In the next number of the Journal an abstract will be given of some of the important papers read at the Congress.

"AFTER-CARE" ANNIVERSARY.

BETHLEM ROYAL HOSPITAL, 2ND JULY, 1885.

Were present: Dr. John Ogle, who, in absence of Earl of Shaftesbury, was called to the chair, Lord Cottesloe, Dr. Clay Shaw (Hon. Treasurer), Dr. Norman Kerr, Dr. Savage, Dr. Seward, Dr. Fly Smith, Rev. F. H. A. Hawkins,

Rev. Fredk. Hall, Mrs. Curteis, Mrs. Ellis Cameron, Mrs. Hawkins, Mrs. Puttock, Miss Fleet, Miss H. J. Hawkins, Mrs. Savage, &c.

Lord Shaftesbury communicated to Dr. Savage his inability to preside. Apologies were read from Dr. Maudsley, Dr. Edgar Sheppard, Dr. Lockhart Robertson (by telegram), Capt. Maberly, Mr. Shaw Stewart, Bishops of London and Bedford, Sir W. H. Wyatt, Lord and Lady Brabazon, Miss L. Twining, &c.

An extract of a letter from Sir W. H. Wyatt was read, in which he said: "The effort to promote an 'After-Care' Home has my sincere sympathy, and I will with pleasure contribute to it when it is started. I believe, if judiciously managed, it may do much good. The great thing will be if those who work it can succeed in placing out in the world discharged patients who may have had a time of residence in the Home. If they are able to do this, I feel sure the Colney Hatch Committee will be able, from a charitable fund at their disposal, to work with and assist them."

Minutes of last meeting were read, and also brief reports of the "After-Care" meeting at the Mansion House, on 30th October, 1884; of the Ladies' occasional Committees; of the Bazaar at the Kensington Town Hall on the 19th and 20th of May; and of some cases to which relief was afforded.

The HON. SECRETARY called attention to the original resolution of 1879, with respect to the undesirableness, for the present, to form a distinct "Home." He also suggested: 1st. That only those convalescents from asylums should be receivable into Homes who were absolutely discharged, and not merely "on trial;" that (2ndly) ordinary convalescents, as well as mental, should be admissible, with priority of reception reserved for the latter class; (3rdly) that mental Homes might do "preventive" service; and he concluded by restating his conviction, expressed at two former anniversaries of the need, in interests of "After Care" Association, of a Secretary able to devote far more time and special attention to the objects of the Association.

Dr. D. HACK TUKE referred to his association with the original resolution of 1879, viz.: "That it was not desirable at present to promote a separate Convalescent Home." He remarked that at that time change of scene and air (in existing institutions), provision of clothing, &c., were contemplated. He did not wish to discourage the project of a separate institution, but was not £300 (the sum named in Dr. Shaw's estimate as the annual expense of a Home with four beds) a large yearly outlay for the maintenance of four convalescents?

Dr. SHAW observed that the accommodation for four inmates would be available for convalescents in *successive relays*.

Dr. NORMAN KERR considered that the actual commencement of work would elicit further help. He instanced the circumstance of his having advanced £6,000 in the establishment of a Home, which sum had eventually been repaid; and he suggested the expediency of registering the design under the limited liability provisions.

Dr. SAVAGE referred to the greater advantage under which convalescents recommenced life's duties after intermediate sojourn in a Convalescent Home. The change had the effect of partly effacing the remembrance of asylum life. He considered that the public would have more confidence in mental convalescents who returned to life's duties after residence in Homes. He desired that *mental* ailments should be regarded more in the same way as *physical* maladies, chest complaints, fractured limbs, &c. The success of the convalescent treatment at Whitley was instanced.

Mrs. ELLIS CAMERON alluded to the special and more than proportionate increase of funds in the past year, also to the liberal responses made to appeals, and to work which might be accomplished in a Home for mental convalescents.

Dr. CLAY SHAW made a statement of funds in the Hon. Treasurer's hands. He requested instructions for the disposal of the money, of which a portion had been given specifically for the promotion of an "After Care" Home. Either

authority should be given to recognise a home, or the money should be returned. "After care" was needed; outgoing convalescents were often assisted by the liberality of nurses. He remarked that a banking account had been opened—Union Bank, Argyll Street—and that some subscriptions were unpaid. He moved the resolution: "That it is desirable to recognize the principle of forming a distinct Home for the reception of females discharged 'cured' from lunatic asylums."

Eventually it was proposed by Rev. FREDK. HALL, and seconded, "That the report of the Treasurer, viz., 'That the estimated expense of a "Home" for four beds would be £300, of which amount five-sixths is either in hand or already promised,' leads this meeting to the belief that the time has now arrived for taking steps for actual work without further delay. That the under-mentioned be appointed a Sub-Committee to consider the practicability of the above resolution, and to report to a general meeting of this Society."

After votes of thanks to Dr. Savage and Dr. Ogle, the meeting separated.

Obituary.

DR. EDWARD JARVIS,

An Honorary Member of the Association, was born in Concord, Mass., January 9th, 1802. He graduated at Harvard in 1826, and took his degree in medicine in 1830. He practised medicine two years in Northfield, Mass., five in Concord, Mass., and five in Louisville, Kentucky, with but moderate success. His tastes inclined him to the study of mental science and anthropology, and he lacked confidence in the effects of his remedies. He was early interested in the cause of education, and started public libraries in Concord and Louisville.

In 1836, while at Concord, he received an insane young man from Cambridge into his house for treatment, and, in a few months, he was well. Several other patients were afterwards received, and he thus became interested in the treatment of insanity, which specialty he resumed at his home in Dorchester, and continued for many years successfully. Dr. Jarvis was disappointed several times in obtaining the superintendency of certain insane asylums in Massachusetts, for which positions he brought the highest recommendations, and for which his tastes strongly inclined him. He felt these disappointments keenly, but was not deterred from pursuing his favourite studies as far as possible in the community at large.

He removed to Dorchester, Mass., in 1843, where he remained until his death. At about the time of this removal, his attention was directed to the apparently excessive amount of insanity among the free coloured population of the North, as indicated by the United States census of 1840. This excess had been used by Southern statesmen in Congress to show the probable effect of emancipation on the negro. Dr. Jarvis showed that the census was grossly in error in this respect. His aid was solicited in the preparation of the census of 1850, and, without official authority, he gave one-third of his time for three years to perfecting the reports. In 1874 Government acknowledged his claim by paying for his services. He was again employed on the censuses of 1860 and 1870, and became the leading authority on vital statistics, and was recognised as such at home and abroad.

In 1854 he was made a member of the Lunacy Commission to inquire into the number and condition of the insane in Massachusetts, and the Northampton Hospital was erected in consequence of their recommendations.

In 1843 he became a member of the Corporation of the School for Idiots in

Boston, and in 1849 was appointed physician to the Institution for the Blind. He continued to be associated with Dr. S. G. Howe in the supervision and care of those two institutions for many years, his services being largely gratuitous.

In 1860 Dr. Jarvis visited Europe, where he travelled extensively in charge of an insane gentleman of wealth, who was accompanied by his family. He was commissioned a delegate to the International Statistical Congress in London, where he made the acquaintance of many distinguished foreign physicians and scientists. He was chosen one of the two vice-presidents on that occasion. He visited a large number of the hospitals, insane asylums, and prisons in England, forming an acquaintance with Sir James Clark, Florence Nightingale, and other philanthropists of the period. The private insane asylums, of which there were one hundred and thirteen, especially interested him, on account of the comparative absence of restraint, and the home-like appearance of the old mansion houses which had been re-modelled for the care of the insane. On his return from Europe, he opened correspondence, and established exchanges, with many foreign statisticians.

In 1874 his labours were suddenly arrested by a stroke of paralysis. He remained in comfortable health, however, till October 20th, 1884, when a second attack occurred, which terminated fatally October 31st. His wife died the second day after, and they were both buried the same day, in their native town of Concord.

Dr. Jarvis' writings were voluminous, and embraced a wide range of subjects. His papers on "Vital Statistics," "Hygiene," and "Insanity," number over one hundred and fifty. He wrote also a *School Physiology*, which was translated into Japanese, and is in use in Japan. His library was extensive and unique of its kind. With the exception of certain special donations of books to Harvard College, the Concord Public Library, and the N.E. Hospital for Women and Children, it was bequeathed, with all his "books, works, and pamphlets," to the American Statistical Association of Boston, of which he was for 31 years president.

Dr. Jarvis was a Fellow of the American Academy of Arts and Sciences, member of the Association of Medical Superintendents of American Institutions for the Insane, of the American Social Science Association, honorary member of the British Medico-Psychological Association, &c., &c.

I am indebted to Dr. Robert W. Wood, of Boston, for many of the above facts. He was a connection of Dr. Jarvis, and wrote a memorial of him for the American Statistical Association. I was somewhat acquainted with Dr. Jarvis, and knew him to be an earnest and "life-long seeker after the exact truth with reference to man in his highest interests and relations." He was painstaking and industrious in the extreme, as his statistical labours proved. He was not only an anthropologist and pioneer in this country in statistical science, but a philanthropist also, having deeply at heart the welfare of all the helpless and dependent classes of society.

As more than confirming the statement in the above notice—for which we are indebted to Dr. T. W. Fisher, of the Lunatic Hospital, Boston, Mass.—we may add the following short extract from Dr. Pliny Earle's work, "*The Curability of Insanity*":—"Familiarity with the writings of Dr. Jarvis, and a personal acquaintance with him of not less than thirty-five years, have led me to regard him as one of the ablest statistical philosophers of the United States. Perhaps no American has been more deeply interested in the subject of insanity than he, and few have made themselves so extensively acquainted with its literature." "He is a conscientious searcher after truth, and no less conscientious in the expression of what he believes to be the truth."

PROFESSOR BIAGIO G. MIRAGLIA.

The following obituary notice of this well-known Italian alienist and phrenologist is derived from details supplied by his son:—He was born on August 21, 1814, at Cosenza, in Calabria, where his father was a magistrate. In spite of delicate health, he early showed signs of literary and artistic ability. After completing his medical studies he began practice in a remote district of Calabria, but soon returned to Naples, where he was appointed on the staff of the Royal Asylum of Aversa. On becoming the director of this institution he devoted himself to its improvement in all respects. But his great energy sought for outlets in other directions, establishing the "*Società Frenopatica Italiana*," and a literary and scientific society; and sharing the fate of Poerio and other political prisoners, in the latter days of the Bourbon rule. He published a large number of separate essays on various medico-psychological and medico-legal subjects; edited from 1860 to 1868 the "*Annali Frenopatici Italiani*," which he established; and issued copious and detailed reports of the asylum at Aversa. But his favourite study was phrenology, which he embraced in early life; and his "*Trattato di Frenologia applicata alla medicina, alla giurisprudenza, &c.*," published in 1853, contributed more probably than any Italian work to spread a knowledge of Gall's system. His life was a striking example of devotion to his profession, and to science; he was as ardent a student at 70, when his career ceased, as at its commencement.

SANITARY GAS-MAKING.

We call the attention of Asylum Superintendents to an advertisement respecting a new gas-making process, which is said on good authority to be specially adapted to asylum gas works. One of our members, formerly the superintendent of a county asylum, has visited, with Mr. Spice, C.E., the Tunbridge Wells Gas Works, and he informs us that there is no smell whatever, and that flowers grow freely in the garden round the works. The "*Gas and Water Review*," June 26th, 1885, contains a short article by Professor Wanklyn, to which we refer our readers interested in the subject of sanitary gas-making. His conclusion is that "all the nuisances which arise from gas works are avoidable, and that there is nothing in the operation of gas-making which necessarily entails the creation of nuisance. Gas works ought to be as cleanly as water works, and, indeed, ought to exert a distinctly sanitary influence."

The process whereby this has been effected is the Cooper Coal-Liming Process, which in 1883 was introduced into the Tunbridge Wells Gas Works, and from that date Tunbridge Wells has enjoyed the advantage of pure gas and inoffensive gas works.

At the Annual Meeting of the Association of Municipal and Sanitary Engineers and Surveyors, June 25th, the process was discussed, and Mr. Spice said that he had had 40 years' experience in gas manufacture and gas lighting, and that he had now become a staunch advocate of the process of manufacturing gas from limed coal. The saving to the consumer is enormous.

Appointments.

COLLINS, GEORGE F., M.R.C.S., L.K.Q.C.P.I., L.M., has been appointed Junior Assistant Medical Officer to the Hants County Asylum, Knowle, Fareham, *vice* Barker, resigned.

DRESCHFELD, JULIUS, M.D. Würz., F.R.C.P. Lond., has been appointed Visiting Physician to the Royal Lunatic Asylum, Manchester.

GORDON, WILLIAM SPEAR, M.B., B. Ch. Dub., has been appointed Resident Medical Officer for the District Lunatic Asylum, Mullingar.

GRANT, DAVID, M.B., C.M. Ed., has been appointed Assistant Medical Officer to the Hospital for the Insane, Callan Park, New South Wales.

JACKSON, ARTHUR, M.B., B.A. Oxon., M.R.C.S., has been appointed Assistant Medical Officer to the Surrey County Lunatic Asylum.

LAW, JOHN SPENCE, M.B., C.M. Ed., has been appointed Clinical Assistant to the Borough Asylum, Winson Green, Birmingham, *vice* Macandrew, resigned.

MACANDREW, HERBERT, M.B., C.M. Ed., has been appointed Junior Assistant Medical Officer to the Salop and Montgomery Counties' Asylum, *vice* C. H. Hale, M.R.C.S., resigned.

MENZIES, WILLIAM FRANCIS, M.B., C.M. Ed., has been appointed Junior Assistant Medical Officer to the Kent County Asylum, Maidstone.

SIMPSON, HENRY, M.D. Lond., M.R.C.S., L.S.A. Lond., has been appointed Visiting Physician to the Royal Lunatic Asylum, Manchester.

WOOD, T. OUTTERSON, F.R.C.P. Ed., F.R.C.S. Ed., M.R.C.S., has been appointed Resident Medical Superintendent of Sussex House and Brandenburgh House Asylums, *vice* Dr. L. S. Forbes Winslow, resigned.

(Continued from last Number.)

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THE JOURNAL OF MENTAL SCIENCE.

[Published by Authority of the Medico-Psychological Association]

No. 136. NEW SERIES,
No. 100.

JANUARY, 1886.

VOL. XXXI.

PART 1.—ORIGINAL ARTICLES.

On the Alleged Fragility of the Bones of General Paralytics.

By DR. T. CHRISTIAN, Physician to the National Asylum of Charenton.*

The title of the paper which I am about to have the honour of reading before you indicates of itself my non-belief in the existence of a change in the osseous system which is the result simply of the fact of general paralysis, this change exemplifying itself in a greater tendency of the bones to fracture.† This opinion coming in opposition to that now prevailing, I propose to make you the arbiters of the question, and will lay before you the arguments which have convinced me.

Some years back when, during a discussion which had arisen at the Medico-Psychological Society on the subject of non-restraint, I denied the existence of this osseous change, this denial brought upon me the following very categorical response of Dr. Foville:—"From the examination which I have made of English literature on this subject," said this distinguished observer, "and from investigations which I have been able to control at my own autopsies on general paralytics at Charenton, I have come to the conclusion that the osseous framework of general paralytics undergoes a change which renders it more friable, and that thus under the simple pressure of the finger it is often possible to fracture the ribs at the autopsy. It is true," he adds, "that such is not observed in all cases of general paralysis, but is so more especially in those cases which show trophic lesions."‡

* Paper read at the Antwerp Psychological Congress, at the Session of the 8th of September, 1885.

† A statement to this effect my colleague Ritti and I have already made in our article on General Paralysis in the Dictionary of Dechambre.

‡ "Annal. Méd. Psychol.," Nov., 1880, p. 666.

This statement of M. Foville is very definite, notwithstanding his reservations. Other authors, such as M. Bonnet, go still further; indeed, so far, as to consider general paralysis not merely as a simple meningo-encephalitis, but in some degree as a disease *totius substantiæ*, expressing itself simultaneously in a change of all the tissues—attacking at one and the same moment the whole organic system.

If I am unable to admit these conclusions it must be clearly understood that I do not in any sense dispute the observations which have been placed on record; I am perfectly willing to allow that in certain cases of general paralysis a softening of the bones has been met with—a veritable osteomalakia. These are recorded facts before which I must bow. But the question does not rest precisely here; that which it concerns us to know is whether general paralysis itself entails an osseous change, such as that described, or whether the osteo-malakia described is but accidental. It is the former proposition to which I cannot assent.

It may seem strange that a question of this nature should have remained undetermined. What more easy, indeed, than to examine microscopically the bones of general paralytics and to determine whether they really are changed? I am not aware, however, that investigations of this nature have been followed up systematically. For my own part I began such when at Maréville. Assisted by one of my *internes*, M. Mabile, now one of our most distinguished colleagues, I had commenced a systematic examination of different portions of the skeleton of paralytics who had died in my wards, as also, for comparison, of the bones of other insane subjects. Circumstances did not permit of my continuing this investigation, which, however, may be easily resumed; but I must say that from the small number of bones which I was able to examine I obtained only negative results. The *direct* method just described not having been employed, there only remain for our purpose isolated observations and statistics.

Isolated observations are not numerous, nor are they equally valuable, the diagnosis not having been rigorously made in all cases. Already in 1842 Dr. Davey had recorded the singular case of an insane patient who had six spontaneous fractures of the long bones (femur, clavicle, left humerus, right radius). This physician concluded, from this case and from certain others, that osteo-malakia may be associated with insanity, and more particularly general paralysis.

Later, Virchow and Litzmann admitted that a kind of osteo-malakia might result from nervous affections.

Yet other authors have admitted the co-existence of these two affections, but this is more positively asserted in the work which Biante, influenced by his master, Henri Bonnet, published in the "*Annales Médico-Psychologiques*" for November, 1876. On the basis of a single observation this doctrine has had the good fortune to be accepted and cited by Professor Verneuil, and after him by many others, without the least reservation or criticism. This unique observation, for the simple reason that it is for ever being instanced, we must examine more closely.

The case is that "of a man, *æt.* 50, a labourer, in whom, as an out-patient, general paralysis is said to have been diagnosed in October 1875—this together with remitting intellectual disturbances." The mental trouble becoming worse the patient was brought to the asylum on the 30th of January, 1876, in the following condition:—"The movements of the limbs extremely inco-ordinate, so much so that, whilst being led by the police, he has the appearance to outsiders of a drunken man. The expression of the face (complexion sallow, earthy) and the speech present the characteristic stamp; he is meddlesome, dirty, and quite demented, although there exist traces of a past delirium, which is *said to have been* (sic.) of an exalted character."

This description is obviously incomplete, and without criticising the diagnosis made by so able a clinician as M. Bonnet I may be permitted to say that the symptoms enumerated by Biante would describe better a dementia of apoplectic, or indeed of alcoholic origin. Is it frequent that one meets with general paralytics, aged 50, who at the end of three months reach the ultimate stage of cachexia, and for whom one is obliged to state hypothetically the nature of the mental affection? Be this as it may, the patient tumbles about, and on the 1st of February, at 4 p.m., he falls in the court-yard and fractures his right radius—I omit details—he dies, on the 6th, comatose. The autopsy is made in a most incomplete manner, for there is mention neither of the brain nor of the meninges; this is the more to be regretted that the diagnosis lacks thus a sanction which is essential here. *Per contra*, the fracture of the humerus is minutely described; it is oblique, very extensive, compound, &c.

From this we arrive at the conclusion that if the patient had not been a general paralytic he would not have inflicted

on himself so serious a damage. It is this conclusion which, to me, seems most hazardous, for we know from experience how many divers elements, often difficult of determination, combine in the mechanism of fractures. We have it from daily observation that most appalling falls occur without any fractures of bones; whilst, on the other hand, a simple false step, a fall of the individual's own height, even on smooth ground, may result in most serious fractures or dislocations. Biante, it is true, adds that the bony tissue was altered, that he was able to establish this, but even then the case is but an isolated one, and does not permit of the generalization which Biante allows himself.

Vallon in his thesis ("On General Paralysis and Traumatism in their reciprocal relations"—Paris, 1882) cites from Régis, of the Ville Evrard Asylum, the case of a man, æt. 35, in the first stage of general paralysis. The same jumps from a window (the height is not stated) and dislocates the astragalus, also fractures his first cuneiform-bone. "It is evident," says Vallon (p. 41), "that in this case the cause of the unusual fracture was the general paralysis." I must confess that I cannot possibly see in the above the relation of cause and effect, and I do not understand why such accident could not have happened to any person other than a general paralytic.

Verneuil ("Soc. de Chirurgie," Séance du 11 Oct., 1876; "Gaz. hebdom.," 1876, p. 669) records a case of osteo-malakia which he observed to arise in a general paralytic, aged 50; but this patient was at the same time diabetic. Verneuil's observation is not without analogy to that of Laehr, published in the "*Allgemeine Zeitschrift f. Psychiatrie*" (Vol. xxxvii., part 1, p. 72), but Laehr does not appear to consider his patient to be a paralytic. His treatise is entitled, "On the Fragility of Bones in the Insane" ("*Knochenbrüchigkeit bei Psychisch Kranken*"), and at the autopsy of the above case he was able to establish the integrity of the meninges and of the cortex of the convexity of the hemispheres.

After all, that we may appreciate with justice all these observations, and understand how, on so small a number of facts, and of facts so far from conclusive, there has been built the theory which I contest, it will be necessary to take strongly into account the actual tendencies of surgery. That which the surgeons, especially of to-day, seek, is the reciprocal influence of traumatism and of constitutional states. If it is believed that this constitutional influence is

to be met with in alcoholism, malaria, diabetes, syphilis; if it has been also found to obtain in certain nervous affections, such as locomotor ataxy, why should it not also have effect in general paralysis? It is permissible to believe that observers have not sufficiently guarded themselves against this preconceived idea, and that they have generalised after too hasty a fashion. With this fault I must tax Arnozan, who, in his degree thesis ("On the Trophic Lesions Consequent on Affections of the Nervous System," Paris, 1880), admits, as proven, an osteo-malakia special to general paralysis. He adds the remark that "it is rarely in the limbs that the fractures are observed; almost always it is a question of fractures of the ribs." This, indeed, is evidence to me that the bones are not more fragile, for otherwise it is the limbs which most often would fracture, being most exposed to falls.

Statistics, German as well as English, do they bring more certain evidence? Gudden ("Archiv. f. Psychiatrie," vol. ii., p. 683) states that of 100 cases of autopsy (50 male and 50 female) he discovered fractures of the ribs in 16. Of these 14 were in men; two were in women. Of the 14 men, eight were general paralytics. These figures are accepted by Schüle in his treatise on psychology. He admits that fractures of the ribs are to be met with in $\frac{1}{16}$ of the cases. Mendel in his treatise on general paralysis brings no new element into the discussion.

These figures have always greatly astonished me, for in none of the establishments with which I am acquainted in France—and I speak of those only to which I have been attached officially in one way or another—have I met with a similar frequency of fractures of the ribs. During a period of more than 15 years of practice, I have scarcely seen four cases, and in these four cases traumatism was undoubted. I must, moreover, remark that statistics based on autopsies are not absolutely reliable, for one must frequently meet with fractures of old date, previous, indeed, to the entry of the patient into the asylum, very possibly previous to the invasion of the mental trouble. Further, it is not denied that many of these fractures, if not most, are due to external violence. This is certainly the case with regard to English statistics. In English asylums many of these accidents have given rise to judicial inquiry, and have even led to the reprimanding of too zealous attendants. The late Dr. Lauder Lindsay, who specially devoted his attention to this question, concludes that if England is the country of non-

restraint, it is also the country of broken ribs among the insane!

It is objected, it is true, that if there are more fractures of ribs in these asylums, this does not result from greater violence on the part of the attendants, but from the ribs of these paralytics being more fragile—in other words, osteomalacic.

Gentlemen, I have no belief in such a position, and should I ever come across a paralytic with fractured rib, I should make search for an external cause. I have, moreover, a clinical argument that to me seems convincing: whosoever has seen and has followed up a case of general paralysis during the progress of the disease, will not have failed to recognise the impossibility of preventing the patient from falling. During one period of the disease the general paralytic falls at least as frequently and as readily as a child learning to walk, and he falls in just the same way, tripping at the least obstacle, and making no effort to save himself. Now since I have been in charge of the male wards of the Charenton Asylum there have passed through the wards during six-and-a-half years about two hundred and fifty general paralytics. Calculate, I beg of you, the number of falls which these patients will have suffered during this period, falls in the courtyard, falls on the stairs, falls in the dormitories, falls in the gardens, and then say if my infirmary should not constantly show some of these cases with more or fewer fractures!*

And yet, gentlemen, I can assure you that during this period of six-and-a-half years I have not come across a

* The number of general paralytics admitted into the male wards was as follows:—

1879	...	...	...	...	...	...	37
1880	...	...	...	...	...	...	36
1881	...	...	...	...	...	...	43
1882	...	...	...	...	...	...	25
1883	...	...	...	...	...	...	27
1884	...	...	...	...	...	...	36
First six months of 1885...	...	...	...	...	...	...	15
Total	...	...	...	...	...	...	219

Those in the asylum on Jan. 1, 1879, numbered more than 30, so that I have in round numbers put all the cases at 250.

During the same period my colleague, Ritti, has had under his charge some thirty female cases. In none has he observed fractures; his opinion completely accords with my own.

single case of fracture—I repeat, not a *single case* in a general paralytic.*

I must end here. I trust you will come to the conclusion with me that general paralysis does not in itself entail any increased fragility of the bones and that osteo-malakia when present is a purely accidental phenomenon, the result of other causes.†

Some Points in Irish Lunacy Law.‡ By CONOLLY NORMAN, F.R.C.S.I., Medical Superintendent of the Monaghan District Asylum.

At a period like the present, when lunacy legislation is attracting much attention, it is interesting to note the various peculiarities of the law as it now exists in various countries. I have no doubt that most of those who listen to me have seen the Blue Book which the Government caused to be published giving some account of the laws dealing with lunatics in several lands, but many who have not practised in Ireland are unacquainted with the very

* I subjoin for comparison the following list of fractures, the only ones I have observed since 1879:—

P—, an epileptic, fall, during a fit, on the pavement of the court yard; fracture of the forearm.

F—, maniacal, discharged cured; attempt to jump over a bench; fracture of the clavicle.

C—, the subject of melancholia; discharged cured; attempt to climb a railing; sprain of foot, and fracture of the internal malleolus.

R—, the subject of apoplectic dementia; æt., 65; fall out of arm-chair on to the floor of room; fracture of the neck of the femur.

S—, folie circulaire; fall in his room during the period of excitement; fracture of the clavicle.

Lastly, at the very moment at which I am writing this, I have under observation a maniacal patient, the subject for more than five years of locomotor ataxy. During a struggle with another patient, he was thrown down and his leg fractured. This accident happened on the 15th of June. To-day, the 10th of August, the patient has left the surgical wards, and has again come under my care, the fracture completely united.

† At the conclusion of my discourse I was fortunate enough to hear M. Ingels, of Ghent, who stated that his personal experience confirmed on all points the views just enunciated by me—that for more than 25 years during which he had had supreme charge of the Guislain Asylum he had seen very few fractures, and these scarcely ever affecting general paralytics. I attach great importance to the opinion of so experienced a physician.

M. Morel, who for 17 years has been physician to the female insane asylum at Ghent, has been so kind as to write me that during these 17 years he has not met with a single case of fractured ribs, and but three or four other fractures, of which one happened to an insane ataxic patient.

‡ Read at the Quarterly Meeting of the Medico-Psychological Association, held at Bethlem Hospital, November 17th, 1885.

remarkable features which the lunacy law of that part of Her Majesty's dominions presents. It is true that geographical proximity, or even membership of the same kingdom, does not always connote similarity in social conditions; and the social conditions of any country are as important an element in legislation for the insane as for the sane. Nevertheless even from Ireland instruction may sometimes be obtained, though perhaps some will say that that land more often affords examples for avoidance than for imitation.

I cannot pretend to any originality in the remarks that follow, and the facts I mention will be already familiar to those who have practised in lunacy in Ireland. My observations refer almost exclusively to that branch of the law which deals with pauper lunatics.

The statute under which patients are most commonly admitted to Irish pauper lunatic asylums is the Act 30-31 Vict., cap. 118. The title of this Act declares it to be "An Act to provide for the Appointment of the Officers and Servants of District Lunatic Asylums in Ireland, and to Alter and Amend the Law relating to the Custody of Dangerous Lunatics and Dangerous Idiots in Ireland." In the preamble reference is made to former Acts which required amendment, of which the most recent was the statute 8 and 9 Vict., cap. 107 ("An Act for the Establishment of a Central Asylum for Insane Persons charged with Offences in Ireland; and to amend the Act relating to the Prevention of Offences by Insane Persons," &c.)

These titles at once suggest that the primary object of legislation is the safe custody of individuals whose insanity made them dangerous to society, and not the cure or tendance of the insane. It is abundantly evident that such was the feeling in the minds of those who framed the Acts, as the sequel will show.

The tenth section of the Act 30-31 Vict., cap. 118, runs as follows:—

10. From and after the First Day of *January* One thousand eight hundred and sixty-eight whenever any Person shall be brought before any Two Justices of any County, County of a City, County of a Town, City or Town, and it shall be proved to their Satisfaction that such Person was discovered and apprehended under Circumstances denoting a Derangement of Mind, and a Purpose of committing some Crime for which, if committed, such Person would be liable to be indicted, the said Justices shall call to their Assistance the Medical Officer, or, if there be more than One, the nearest available Medical

Officer of the Dispensary District in which they shall be at the Time, and if there shall not be any such Medical Officer available, then the nearest available Medical Officer of any neighbouring Dispensary District, who shall examine such Person without Fee or Reward ; and if such Medical Officer shall certify that such Person is a dangerous Lunatic or a dangerous Idiot, it shall be lawful for the said Justices, by Warrant under their Hands and Seals, to direct that such Person shall be taken to the Lunatic Asylum established either wholly or in part for the County, County of a City, or County of a Town in which he shall have been apprehended ; and every such Person shall remain under Confinement in such Asylum, and be there maintained, in like Manner and subject to the same Conditions as if such Person had been removed from any Gaol to such Asylum by virtue of the Warrant of the Lord Lieutenant under the Provisions of the recited Act of the First Year of Her present Majesty, Chapter Twenty-seven : Provided always, that nothing herein contained shall be construed to restrain or prevent any Relation or Friend from taking such Person under his own Care and Protection if he shall enter into sufficient Recognizance for his or her peaceable Behaviour or safe Custody before Two Justices of the Peace, or the Chairman of the Court of Quarter Sessions of the County in which such Person shall be confined, or One of the Judges of Her Majesty's Superior Courts at *Dublin*.

The first part of this section is merely a modification of the older laws, giving the justices the power of committing a dangerous lunatic or dangerous idiot to gaol, "there to be kept in strict custody." At the time when there were no lunatic asylums in the country it was, doubtless, absolutely necessary to send unmanageable lunatics to gaols. When the Act before us was passed (1867) it became illegal to send lunatics to gaol as such (section 9). Unfortunately no other means of dealing with the necessities of the case appear to have occurred to the framers of this Act than simply to adopt the old mode of procedure so far as to direct that lunatics be sent to asylums instead of prisons, altering nothing but the destination of the lunatic. The old way of disposing of a troublesome lunatic had been found in practice ready and expeditious, and its calamitous influence on the insane, if it was ever observed, was confounded with the effects of the still more objectionable incarceration which followed. Besides, when people were to be imprisoned in a common gaol it seemed only right that they should have at least a form of trial, however summary.

As the law now stands we find that the great bulk of the patients received into an Irish asylum (in some districts

all) go through the following process: They are first apprehended by a couple of policemen. They are then brought either to the Petty Sessions Court, if it happens to be sitting at the time, or frequently to the residence of a magistrate, or perhaps most commonly to the police barracks, where two magistrates have been hastily summoned. Then a deposition is sworn, generally by a near relative of the lunatic, setting forth what acts he has been guilty of, denoting a derangement of mind and a purpose of committing an indictable offence. The medical officer of the dispensary district (who answers to the English parish doctor) examines and certifies. The magistrates issue a warrant ordering the patient's admission to the asylum, where he is then conveyed by two policemen. To those who are not familiar with these functionaries it may be mentioned that policemen in Ireland usually go about fully armed, and are more like riflemen than English constables. It often happens when two magistrates are not at once procurable, or when the distance to the asylum is great, that the patient is kept overnight in the police barracks.

It does not need to be pointed out how injurious to the unfortunate lunatic all this show of force and parade of legal terrors may be, nor how it must hurt his feelings if they are not entirely blunted by disease. These faults lie, as it were, on the surface, but the system has the radical fault of confounding lunacy and crime, though the tendency of all other modern legislation is to distinguish between the criminal and the lunatic. It is not a metaphysical subtilty to say that in many cases an unhappy lunatic is sworn to have exhibited derangement of mind and a purpose of committing an indictable offence, when in truth his derangement of mind was such that he acted quite without any purpose. Insanity, taking any form except that of complete dementia, may manifest itself by an apparent purpose of committing an indictable offence of some sort, and instead of providing a pardon for acts done or purposed to be done under the influence of insanity, the statute we are considering constitutes a new crime, that of being a "dangerous lunatic."

Magistrates take very various views of their duties and responsibilities under the provisions of this Act. I have known magistrates refuse to commit in cases where most medical men, and certainly any specialist, would unhesitatingly have borne testimony to the danger that would follow

if the patient remained at large—for example, cases in which assaults had been committed prompted by auditory hallucinations. But in the generality of cases the magistrates are very easily satisfied. It is recognised that the procedure under this Act gives a ready means of sending a lunatic to an asylum, and accordingly arrest, deposition and committal are looked on as simply the usual and proper steps in the process of sending an insane man or woman to a place where he or she will be safe and will be kindly treated. It is a curious preliminary for a course of non-restraint; but such it generally is. Of course the real object of any magisterial inquiry there may be is to discover first of all whether the individual apprehended is insane, and most magistrates are content if this point seems evident; but the form gone through makes the purpose of committing an offence appear the most essential part of the prisoner's crime. Herein the Irish proceedings differ entirely from those of some other countries, the State of Illinois for example, where trial by jury precedes the confinement of any patient in an asylum. There is a superficial resemblance, and in both cases, as most people in England will think, there is too much publicity, and too much show of legal intervention. But in Illinois it would appear that the plain issue of the patient's sanity or insanity is the only point left to the jury.

When the two questions are raised of insanity on the one hand, and violence, &c., on the other, we might expect to find much more stress laid on violence than on insanity, as the former is so much more easy to definitely prove than the latter. Accordingly it is the commonest thing in the world to read a committal warrant, in which some such statement occurs as this: "A. B. was arrested under circumstances denoting derangement of mind and a purpose of committing an indictable offence, viz., he threatened to beat his wife, and said he would take the life of his mother-in-law." I have no doubt in such a case the magistrates are perfectly convinced that A. B. *is* insane. They have, however, the same difficulty in stating *why* they have come to this conclusion which is generally experienced by those not accustomed to analysing the symptoms of insanity. It is true that before committing an individual they must "see" him, "examine" him and be "satisfied that" he "is a dangerous lunatic," (such is the language of the warrant), but they are not bound to give any reasons for the decision

at which they arrive further than those mentioned in the deposition. The deposition is often, if possible, even more trivial and irrelevant than that which I have described.

With reference to the medical certificate, all that the Act requires is that the doctor shall certify that the person apprehended is a dangerous lunatic or idiot; but in the forms attached to the warrant there is appended to the medical certificate a "statement of particulars of case" which is also signed and certified by the medical man. The meagreness of the information conveyed by this statement is a frequent source of complaint among superintendents, who receive no help from a brief recapitulation of the facts mentioned in the deposition. There are six columns in the statement: (1) Species of Insanity; (2) Probable Cause of Derangement; (3) Prominent Symptoms; (4) Whether Affected with Bodily Disease; (5) Whether Idiotic or Epileptic; (6) Facts Indicating that the Patient is a Dangerous Lunatic or Idiot. In my experience the column for Prominent Symptoms is most commonly filled up in one word, thus, "Violence," and the column for Facts Indicating that the Patient is a Dangerous Lunatic thus, "Has committed assaults." The bias of the constable, which characterizes the whole business, affects even the doctor. It is the rarest thing possible to obtain from any portion of these warrants and forms any information, unless that of an attempt at suicide, which can be of the slightest value in endeavouring to form an idea of the case.

It is to be observed that the facts indicating insanity are not necessarily facts observed by the medical man. The distinction existing under the English Lunacy Law between facts which one has one's self observed and facts reported by others is ignored, and consequently the "facts" in the Irish certificate are mostly quite worthless, even if they are given in any detail.

As might be expected, where no classificatory or other hint is given, and the matter is merely left to the taste and fancy of the certifying medical man, the column for form of insanity is valueless. I have frequently seen certificates in which the form of insanity is stated to be "Idiocy," though the duration of illness, as stated in another portion of the form by the patient's son or other relative, may not exceed a week. In short, since the medical man is not required to say on what grounds he has formed his opinion of the patient's insanity, the whole statement of particulars is

needless, and appears to be regarded by the signatory as a mere idle form. The Act, as above-mentioned, absolutely requires only a certificate that the person is a dangerous lunatic or idiot.

The concluding portion of the section with which we have dealt contains a very remarkable provision, whereby any relation or friend of an individual committed to an asylum as a dangerous lunatic or idiot has the power to take such person under his own care on giving bail for the patient's peaceable behaviour or safe custody. This passage is very much on a par with the rest of the section in its mode of regarding the lunatic. If the person committed to a lunatic asylum is an ordinary criminal, the fact that his friends give bail for him may well prevent a repetition of his offence, but it is an amusing puzzle to try and understand the point of view from which those law-givers looked at insanity who could fancy that any amount of recognizances of relatives or friends would be to a homicidal or suicidal lunatic an adequate deterrent from acts arising out of his unhappy mental condition. It may be said that the person entering into recognizances is responsible, and that it will be his decided interest to restrain the individual for whom he has gone bail. But if it was necessary to remove a lunatic from his home and commit him to an asylum with all the legal formality that has been described, this in itself is surely a sufficient proof that his relatives and friends have felt themselves unable to restrain him.

It is a curious fact that the law does not require that the person who has sworn the deposition in reference to the lunatic should be the bailsmen, nor the lunatic's nearest relative, nor his legal guardian, but merely says "any relation or friend." In fact, anybody may remove a dangerous lunatic from an asylum on giving bail.

The amount of bail is not fixed, and therefore rests with the discretion of the magistrates.

Very untoward consequences have occasionally resulted from the action of this law, and seeing the kind of patients frequently discharged under its provisions, one can only wonder that disasters are not more common.

Happily the very summary mode of committing a patient assists in the prevention of mishaps. Patients are often removed on bail and recommitted as dangerous lunatics within a very short period. I presume the recognizances of the bailsmen could be forfeited in such a case, but I have never

known this to be done. No doubt the magistrates are unwilling to put any obstacles in the way of the speedy re-admission of patients believed to be dangerous.

What change, then, is suggested to remedy this unfortunate condition of affairs?

Should legislation in lunacy not take a form that will assimilate the rules as to admission, &c., in the three kingdoms, still an improvement in the Irish law would be peculiarly easy. For there is another method of admission of pauper patients—unhappily little used—which could be readily modified in such a way as to do away with any necessity, or supposed necessity, for the Act 30 and 31 Vict., cap. 118, and to simplify legislation considerably. I refer to the procedure under the provisions of Nos. XI., XV., and XVI. of the “General Rules and Regulations for the Management of District Lunatic Asylums in Ireland,” issued by the Lord Lieutenant and Privy Council. These Rules have in Ireland the force of statute. They provide that a lunatic may be admitted on the authority of the Board of Governors when an application shall have been duly made for his admission in accordance with the prescribed form. The form includes a stamped declaration made before a magistrate, to the effect that the individual to be admitted is insane and destitute, together with a certificate signed by a magistrate and clergyman, or poor law guardian, stating that they have inquired into the individual’s case, and that they believe him to be a lunatic in destitute circumstances. A medical certificate is also required stating that the individual is insane, and that, “from the nature of his malady, he is a fit subject for speedy admission into the district asylum.” Appended to these is an “engagement to remove” (the lunatic) “to be entered into by the applicant for the lunatic’s admission;” a very useful instrument, whereby the applicant binds himself to remove the patient whenever the Inspectors of Lunatic Asylums or the Board of Governors shall call upon him to do so. To avoid delay, the Governors only meeting once a month, the resident physician has power to admit at once should he deem the case urgent, reporting to the Governors subsequently and obtaining their sanction.

It appears to have been the intention of the persons who suggested these rules that the mode by application to the Board of Governors should be the ordinary way of admission. Unfortunately, permissive regulations were not sufficiently strong in face of the fatal facilities afforded by the Act 30

and 31 Vict., cap. 118. Besides, admission is compulsory under the provisions of that statute, whereas when an asylum has attained its full limit of numbers, the Governors properly refuse to entertain applications for further admissions. Accordingly, the great bulk of our patients come to us as "dangerous lunatics."

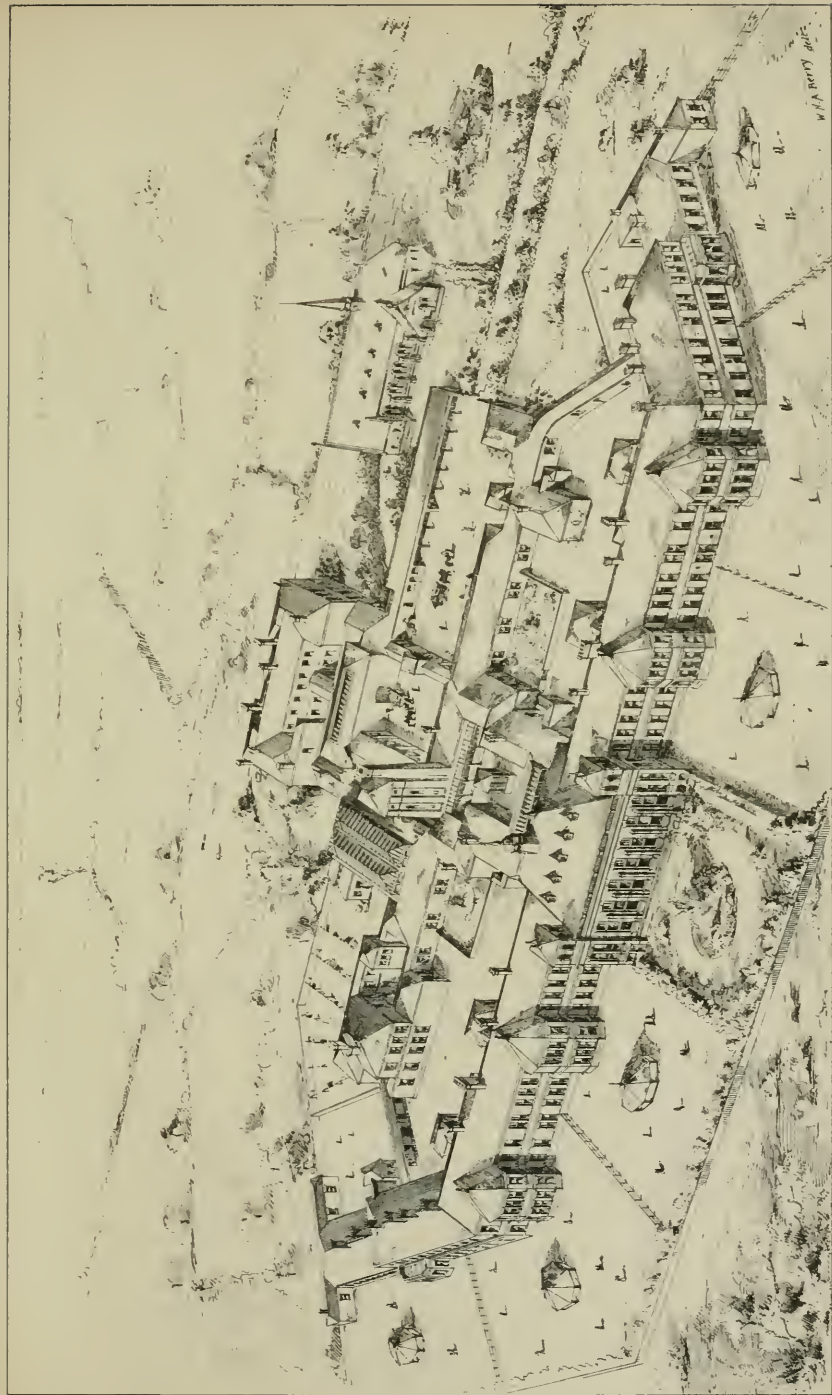
The procedure by means of application to the Board of Governors for admission—so far as circumstances have permitted it to operate at all—has worked perfectly well. It fails in not providing an absolute authority for immediate admission of dangerous cases. I would suggest that the magistrate who signs the certificate endorsing the statement of the applicant should have it in his power to order the superintendent of the asylum to admit the patient, and retain him till the application shall have been laid before the Governors. The magistrate might be empowered to administer an oath to the applicant, and also to the certifying physician; these powers not to be exercised unless in case where the patient is affirmed to have shown tendencies decidedly dangerous to himself or others. At present the magistrate witnessing the declaration may be the same magistrate who certifies that he believes the declaration is true. It might, perhaps, be well that this were altered, or that, in cases where a magisterial order is necessary, this order should be signed by two magistrates. So far from permitting dangerous lunatics (and dangerous lunatics only) to be removed on bail, as the present law does, an amended enactment might, perhaps, allow the removal of any lunatic who had not been admitted on a special magistrate's order as dangerous, in case his relatives or guardian became responsible for his safe keeping. (Of course, discharges under such circumstances occur constantly now). On the other hand, in case of patients admitted on order as dangerous, the order being afterwards confirmed by the Board of Governors, it would, I apprehend, be no injustice to enact that such patients be not discharged uncured, except for the purpose of transfer to another asylum, unless the Board of Governors are satisfied that they have ceased to be dangerous.

The tenth section of 30 and 31 Vict., cap. 118, could be repealed by the same statute that would amend the present regulation in reference to applications.

Design for a Public Asylum for 310 Patients, allowing for extension of Accommodation up to 450 Beds. By C. S. W. COBBOLD, M.D., F.R.C.P. Edin., Medical Superintendent of Earlswood Asylum. (With Plates).

The accompanying designs have been prepared by Messrs. Berry and Burmester, architects, London, in consultation with myself. We do not claim that it is in all respects a model asylum, great economy both in construction and in subsequent administration having been carefully studied throughout. It is believed, however, that it provides at a reasonable cost all the requirements of a modern asylum for the pauper class, that its arrangements comprise everything which is essential to the most approved methods of treatment of insanity, and that it presents novel points and advantageous combinations which render it specially worthy of attention. The design is suited to the requirements of either a small county or a borough, for it contains, in due proportions, accommodation for all the classes of the insane found in our public asylums.

In the more populous counties, where the number of the insane is so large as to necessitate the provision of several asylums, it may be desirable, and it certainly is possible, to separate the chronic and harmless patients from the acute and turbulent, placing them in separate buildings specially designed to meet the requirements of each. This arrangement might also be attained by the smaller counties and boroughs if they were to combine for the purpose; practically, however, the plan has met with little favour in this country, though it is common on the continent. The following are the chief efforts which have been made in England in this direction: Since 1870 the Metropolitan Asylums Board has erected several large asylums affording excellent accommodation exclusively for imbeciles, chronic lunatics and idiots. The Middlesex justices made trial of this system by building their third county asylum (opened at Banstead in 1876) specially for chronic, quiet patients; but accommodation for acute cases has since been added, and all classes of the insane are now treated there. The Lancashire asylums have, during recent years, been provided with large annexes, which, though built upon the same estates with the older buildings, are practically distinct asylums, and are specially calculated for the accommodation of the chronic class. Still, even there



Barry & Burnmaster, Architects.

DESIGN FOR A LUNATIC ASYLUM.
GENERAL VIEW FROM PATIENTS' FRONT.

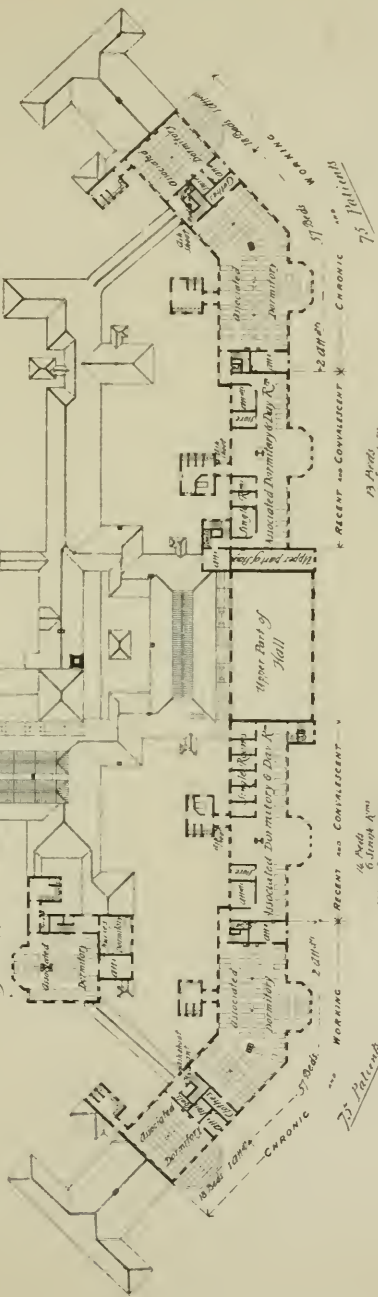
J. Akerman. Photo lith London

Medical Officers' Residence

Officers' Residence



LAUNDRY WARD.
25 Patients



BERRY & BURMESTER
Architects
35, Abchurch Lane,
London W.C.

13 Beds
4 Single 90
Total 57 Patients

Scale of Feet

10 20 30 40 50 60 70 80 90 100

16 Beds
4 Single 80
Total 50 Patients

75 Patients

Upper Floor

DESIGN FOR A LUNATIC ASYLUM.



the original asylums still contain a mixed population, and no asylum has been specially constructed or reserved for the hospital treatment exclusively of acute and recent cases.

Much has been recently urged in favour of providing small hospital-asylums into which all recent cases of insanity should be first received, and in which they should be actively treated so long as any prospect of recovery exists. Under this arrangement only incurable patients would be passed on to the older asylums whose functions would thus become purely custodial. The nearest existing approach to such a hospital-asylum in this country is the Bethlem Asylum, where curable cases are received for *one year* unless cured sooner; the year may also occasionally be exceeded if there is still a prospect of recovery. But Bethlem is a charitable institution, and no State asylum has yet been conducted upon this system. It is not proposed to discuss here the advantages and disadvantages of this method as applied to public asylums, but the fact must be recognised that the justices charged with supplying accommodation for the insane poor have not hitherto adopted it, and that in nearly all county and borough asylums the various classes of the insane are brought together under one roof.

The plan now to be described is therefore adapted to the system universally followed in boroughs and in the less populous counties; appropriate accommodation is provided for each class of patient in wards specially arranged to suit their various requirements, thus making provision for suitable classification. At least four distinct classes of patients are recognised in each sex, and wards proper for each are supplied accordingly. Each ward may be regarded as a separate hospital or asylum with its own particular function and aim, but all being under one roof, patients may be transferred from one to the other as often as may be desirable with much greater ease than would be the case if a separate and distinct asylum were provided for each class of patient. These advantages are not, of course, peculiar to the present plan, but are shared by it in common with most well-constructed public asylums.

And first as to the general plan of the asylum building. I am strongly of opinion that for large public asylums (say 600 beds and upwards) the separate block system is far superior to any other. As the most excellent and recent examples of this may be mentioned the new county asylums at Cane Hill (Surrey) and at Gloucester; also,

though not quite so recent, the Middlesex County Asylum at Banstead. For smaller asylums, however, the separate pavilion system is too expensive both in construction and administration for adoption by public bodies; the special circumstances, moreover, which render its adoption so desirable in the case of very large asylums are not present in the same degree in smaller institutions.

It is believed that the plan now submitted combines most of the advantages of the block system with the convenience of the old succession of gallery wards, and that it avoids the chief disadvantages of each. In the block system each pavilion is surrounded on all sides by fresh air, thus affording special facility for lighting and ventilation, also great variety of aspect and prospect. In the present plan each ward is open to the air on both sides, being lighted and ventilated by windows throughout its length. The buildings to the north of the wards, moreover, being but one storey in height, there is practically no obstruction to the access of light and air from that side. As in the block system, some of the windows must overlook other parts of the asylum-building, but every ward commands uninterrupted views of the surrounding country from many of its windows. In the block system each ward is a complete administrative unit, shut off from the rest of the asylum; the attendant in charge of it can therefore be held responsible for everything occurring within it, for he is not subject to interference by other persons passing through on their way to or from other parts of the building. The present plan possesses this advantage in the fullest degree, each ward having a separate and independent entrance from the general system of corridors, so that through-traffic is unnecessary and may be forbidden to all except the superior inspecting officials. In the present plan, as in the block system, each ward is complete in itself, containing, in addition to living and sleeping accommodation, lavatories, store-rooms and attendants' rooms, with baths, single rooms, sculleries, &c., wherever they are required.

The chief excellence of the old corridor plan (successive strings of gallery wards) lies in the facility it affords for medical and other supervision by reason of the easy communication from ward to ward. In the present plan this is fully provided for on both upper and lower floors, the supervising officer being able to pass through the whole range of wards without once retracing his steps. The doors of communication are also most valuable as alternative exits in case

of fire or panic. On the upper floor they afford access to additional staircases.

The chief disadvantage of the separate pavilion system, from an administrative point of view (to say nothing of the excessive original cost in small asylums), arises from the loss of time experienced in "going round the wards," owing to the necessary retracing of steps. When the upper floors of the blocks are visited each staircase has to be separately ascended and descended, a length of corridor being also traversed between each block. All this is avoided, as has already been explained, in the present plan. As a general rule in the block system there is but one means of exit from the upper floors, and this is apt to be cut off in case of fire; no such danger exists in the present design. In the block system the wards are so isolated that there must necessarily be some delay in obtaining help from adjoining wards in cases of emergency. No such delay would occur in an asylum constructed upon the plan now proposed; this is specially important in small asylums where, the wards being small, the attendants in each are necessarily few.

The most marked defect of the old system of construction, where gallery wards open one into another, arises from the almost incessant passing of traffic through the wards. This disturbing influence interferes with the comfort and temper of both patients and attendants, it destroys all feeling of homeliness and coziness, leads to disagreements among the staff, and prevents attendants from taking that pride in the appearance of their ward which conduces so much to the happiness and recovery of the inmates.

It should be noted that this last objection holds good with almost increased force in the case of some asylums which are professedly constructed upon the block system. In the buildings to which I refer the corridors which connect one block with another take the form of gallery wards, which, being small, are usually occupied by recent and refractory cases. The very patients whom it is most necessary to withdraw from all disturbing influences are thus unduly subjected to them. This system of construction is advocated on the ground that great waste of space and building material is avoided by utilising corridors of communication as wards. It must, however, be borne in mind that a gallery ward is far more expensive to construct than a simple covered way; also that one of the great advantages of the block system (complete isolation of each block) is counteracted if the

pavilions be connected together by wards, thus allowing an interchange of vitiated atmosphere such as cannot occur if only covered ways with free cross ventilation are interposed between the blocks.

Various plans have been devised with the object of avoiding the evils of traffic passing through the wards. That most generally adopted is the placing of a covered passage beside each ground-floor ward beneath the sills of the single room windows. This mode of meeting the difficulty is the best practicable in many gallery-ward asylums, but it is objectionable, and usually results in the provision of a cramped, low, ill-ventilated passage, at the expense of the proper lighting and ventilation of the ward upon which it abuts. In the plan now submitted each ward has a separate approach through well-lighted and ventilated passages; but these latter are very economically provided, being for the most part placed under the same roof with various parts of the administrative buildings, to which they serve as means of approach and passages of communication.

The present design may be briefly described as follows:—Facing the north is the main entrance; upon one side of it is the medical superintendent's residence, upon the other the committee rooms and clerk's office, with separate accommodation over for the assistant-medical officer, matron, &c. Running directly backwards from this block are administrative buildings in the following order: Steward's stores, engine-house, boiler-house, coal store and bakery, all surrounding the stores yard. Next follows the kitchen department, consisting of main kitchen, scullery, larder, pantry, two mess-rooms for attendants, and a good meat store well placed in the centre of an open court. Immediately south of the kitchen, and separated from it by a cross-corridor, is the large dining and recreation hall, which thus forms the centre of the south front, and is conveniently placed both for the serving of meals from the kitchen and for the access of patients from the male and female departments independently. The hall is capable of seating about 600 persons and is fitted with a raised stage and dressing-rooms. Additional exit doors, communicating through side lobbies directly with the open air, are provided in case of need.

From this hall, as a central feature, the male wards run eastwards and the female wards westwards, all of them facing the south. The wards run in a straight line for only half their length, they are then canted to the north-east and

north-west respectively at an angle of 45 degrees. This has the effect of bringing the more distant wards much nearer to the central administrative departments, thus producing compactness and avoiding useless lengths of communicating corridor, while at the same time preserving to each ward a large element of southern aspect and providing an increased range of view from the windows. This arrangement also removes to some extent from the general patients' front those wards which are intended to accommodate the most noisy and refractory cases. Another subsidiary advantage is that a good view of the asylum-front can thus be obtained from many more points of the compass than would be the case if the frontage were all in one line.

The wards are nowhere more than two storeys high ; they provide suitable accommodation for four distinct classes of patients of each sex, and comprise in each department: (1) The infirmary for sick and bed-ridden ; (2) a ward for recent and convalescent cases ; (3) the chronic ward for working and quiet patients ; and (4) the epileptic and refractory ward with observation dormitory for suicides and epileptics. On the female side a separate ward for 25 laundry workers is also provided, thus supplying the excess of accommodation which is always required for females in public asylums. In planning an asylum for a larger number of inmates a greater variety of accommodation would of course be provided : the refractory might be separated from the epileptic, the recent from the convalescent, the workers from the harmless idlers, and so forth ; but nine separate wards is a liberal allowance for a pauper asylum with only 300 beds, and it is believed that an experienced superintendent could so utilise the accommodation now suggested as to effect a perfectly satisfactory classification of his patients.

The infirmary ward is in form a combination of a gallery ward with an ordinary rectangular hospital ward ; it is placed upon the ground floor next to the central hall, and is therefore most conveniently placed for access by the medical and other officers. It contains 20 beds (including three single rooms), a day-room with large bay window, separate kitchen, store-room, attendants' room, bath-room (with movable bath), w.c.'s, lavatories, slop sink, &c. A verandah upon the south-front has a door opening directly into it and is fitted with sun-blinds, which would be removed in winter so as not to interfere with the access of light and air.

The reception or convalescent ward is placed upon the

floor above the infirmary, to which it is somewhat similar in shape, but it contains more single rooms and a more spacious day-room. This ward is also capable of further sub-division by means of a dwarf glazed screen placed across it.

The chronic ward is intended to accommodate 75 patients; it consists mainly of a large day-room upon the ground floor and associated dormitories above. The spacious day-room has a large bay window in the south-front and, owing to its canted line of axis, commands from its windows a great variety of aspect and view. The patients for which this ward is intended do not require such constant immediate supervision as is necessary in other wards; they are also prone to form cliques and coteries, each of which likes to appropriate a table or corner in the ward to its own more immediate use. The somewhat irregular shape of the day-room readily lends itself to such arrangements, which are really advantageous in that they allow each patient to "choose his own society" and thus avoid quarrels arising from the forced association of uncongenial temperaments. Independent w.c. and lavatories are placed in this, as in all the wards, upon each floor. Suitable stores for coals and clothing are also provided. The dormitories for this ward extend over the day-rooms of both this and the adjoining epileptic ward; rooms are provided for three attendants, and alternative staircases afford free exit in case of fire.

The ward for epileptics is confined entirely to the ground floor, and is arranged for 30 patients, with rooms for four attendants. The day-room is lighted from both sides and possesses a large bay window, a scullery, and a store-cupboard. The observation dormitory for 24 beds opens directly out of the day-room; it also is lighted on both sides, and has at its farther end a range of eight single and padded rooms; in these latter the beds would be constructed to lock down in position upon the floor. The w.c., bath, and lavatory pavilion is so placed and arranged that it can be made accessible from either the day-room or the dormitory, or can be locked off from either. A room for two attendants is so placed as to overlook both the dormitory and the day-room. One of the baths would be movable, so as to be capable of being conveyed to the bedside of a patient. The single rooms are lighted through thick glass by gas burners placed outside the rooms, and the doors would be fitted with narrow open panels to allow of constant supervision.

The centrally-placed stores and kitchen departments are

flanked by two central corridors, running north and south. Branching off from these at right angles are the east and west corridors which lead to the epileptic and chronic wards. Upon these lateral corridors are situated, on the male side, a range of spacious work-shops and the general bath-house, with dressing-room, lavatory, and w.c.; on the female side, the laundry, laundry ward, sewing-room, general bath-house, &c. The workshops open off the lateral corridor; they also communicate one with another and with an enclosed goods and work yard, the opposite side of which is formed by coal stores and the smith's shop.

The laundry is close to the engine-room and boiler-house, being also easily accessible from all parts of the asylum. It comprises receiving-room, washhouse, drying closet with hot chamber above, ironing-room, sorting and distributing-room, also a separate washhouse for foul linen, and spacious drying ground. The rain-water from all roofs is collected into tanks and made available for use in the boilers and the laundry.

The laundry ward is in direct connection with the laundry itself; it is calculated for 25 patients, the day-room being upon the ground floor, and the dormitories upstairs. Store-room, w.c.'s, lavatories, and attendants' rooms are provided in connection with this ward.

Each general bath-room contains five baths, one of which is partitioned off for the attendants' use; a convenient dressing-room, with fireplace, w.c., &c., adjoins it. The bath-houses not being connected with any ward, can be used independently by the patients from each, without giving rise to administrative friction.

Convenient quarters for the chief attendant and head nurse are placed at the junctions of the central and lateral corridors.

At the north ends of the central corridors are the side entrances for patients, visitors, and servants—male and female respectively. Close to these entrances are good male and female visiting rooms with separate w.c. accommodation for each. Near to the patients' entrance upon the female side are the dispensary and office, which are thus conveniently near to the medical officers' quarters.

The detached chapel, designed to seat 320 persons, is placed near to the patients' entrance upon the male side; it is provided with separate entrances for the sexes, and with waiting-rooms adjoining the lobbies as required by the Com-

missioners. I am personally strongly in favour of having asylum chapels in direct communication with the main building or forming a part of it, thus differing from some high authorities. I know by experience that detached chapels are not used so frequently nor by so large a proportion of patients as those which are attached. Many causes combine to bring about this result. Attendance at a detached building necessitates out-door clothing, and a larger staff of attendants to supervise the patients in going to and fro. In inclement weather several things may happen; either a very small congregation attends, or a large number of patients get their clothes wetted (a serious matter in a pauper asylum, where change of clothing and drying accommodation must be limited and umbrellas are unknown), or the service is hastily held in the recreation hall with unavoidable detriment to a devotional frame of mind. When the chapel is detached its use is generally restricted to Sundays and festivals, daily prayers being said in the hall. When, however, the chapel forms part of the main building, morning and evening prayers are usually held in it daily, the short, bright service, with the organ attracting good congregations. Many runaway and troublesome patients who would not be taken to the services in a detached building, attend them regularly in the asylum, and have no ideas of escape aroused in their minds thereby. If the chapel is used only upon Sundays, it is very apt to be insufficiently heated in the winter; if used daily it is far more likely to be kept comfortably warm. The great argument in favour of a detached chapel is that it is more natural to go out to church than to have a private chapel at home, and that the patients regard attendance at a separate building as something outside their asylum life and prize it accordingly. I cannot attach very much weight to this argument, as it does not accord with my experience, and even during service in a detached chapel the patients are surrounded by the same officials and fellow patients with whom they always associate. The privilege of attending a public place of worship outside the asylum is quite another thing, and is greatly appreciated by those patients to whom it can be safely accorded. In compliance with the recommendation of the Commissioners in Lunacy, the chapel in the present plan has been designed as a separate and detached building, but a covered corridor connecting the chapel with the asylum could be easily provided if thought desirable. The position of the chapel with

respect to the main building might also be varied in accordance with any peculiarities of site.

The sanitary arrangements of the asylum have been most carefully planned. All w.c.'s (and urinals) are placed in separate pavilions, and are cut off from the wards by lobbies with cross ventilation. They would be subjected to periodical flushing by automatic apparatus, in addition to the ordinary flushing after use. This latter is effected by a simple pull fixed in a slot in the wall and connected with an automatic flushing cistern above. All soil pipes would be outside the walls and be carried above the roof. The main drains are planned to run in perfectly straight lines for the longest distances possible; at every point of junction or change of direction is a proper inspection manhole through which the drains run in open channels. No drain passes under any part of a ward or other inhabited portion of the asylum. Where it is necessary for drains to pass under the corridors of communication they are carried in straight lengths of perfectly air-tight construction. All waste pipes from baths, sinks, lavatories, &c., discharge over open intercepting gullies; in connection with these would be fixed automatic flushing tanks by means of which the drains would receive continually and regularly a powerful and effective flushing. The traps in connection with kitchen and scullery sinks are in addition specially adapted for the interception of all grease. Drains would be trapped at all proper points and would be freely and thoroughly ventilated throughout. The drainage could be discharged into a main sewer, or made available for irrigation as might be desired.

Large rain-water receiving tanks are planned at various points and are all in continuous connection. From these the water would be raised, by a lift-pump fixed in the engine room, into a large tank over the boiler-house. From this the boiler would be supplied for laundry, heating and other purposes.

The whole of the wards and administrative buildings (including corridors, bath-rooms, w.c.-pavilions and workshops) are warmed by a system of circulating hot-water pipes, charged with rain-water in order to avoid the incrustations and stoppage which follow the use of hard water for this purpose. In the wards generally the pipes are enclosed in casings constructed to form seats around the walls and bays. Fresh air is admitted through grated flues in the outer walls, it then passes over and along the hot water

pipes and afterwards enters the wards through large hit-and-miss gratings. These last are not placed opposite to the flues in the outer walls, but alternate with them. In the single rooms and other parts where it is not advisable to have the pipes in the rooms, they are laid in channels in the floors, and communicate warmed fresh air to the rooms by means of appropriately placed flues and hit-and-miss gratings. All pipes are easily accessible for examination and repair. All hit-and-miss gratings are made to lock either open or shut. Open fireplaces are also provided throughout the asylum in suitable situations, strong iron guards being always supplied.

Specially constructed windows (to be described later) afford a means of thorough cross-ventilation wherever desired, without exposing patients to direct currents of cold air. Additional and more permanent ventilation is afforded by the provision of flues of special construction, which lead to channels connected with four main extract shafts. In each of the latter a coil of steam pipes is fixed, thus creating a powerful extracting force, the effect of which can be regulated in each ward by means of gratings to lock open or shut. The extract will also be increased by the gas jets provided under the outlets in the ceilings of the wards, above single room doors, &c. Thus are amply secured both the extraction of foul air and its replacement by either warmed or cold fresh air admitted as already described.

The window sashes to all parts of wards, and wherever accessible to the patients, are provided with locks to fasten closed or open at certain regulated heights. They are also formed with an extra wide bottom rail and closing bead on sill, thus enabling the lower sash to be raised sufficiently to form an up-current of fresh air for ventilation at the meeting rails without opening the lower portion to admit draught. Strong simple shutters are fixed in the single rooms to work flush with face of wall both when open and shut; they are also provided with locks for fastening in either position. All windows accessible to patients throughout the asylum are protected on the outside by iron guard bars following the lines of the glazing bars of the sashes, and securely fixed to the brickwork. This arrangement produces absolute safety, but is neither unsightly nor prison-like in appearance. When the windows are closed, the guard bars are not seen from within. From the outside, at a little distance, the guard bars look like the glazing bars of the sashes, and are

therefore not specially noticeable whether the windows be open or shut.

Glazed tubular dust shoots are formed in the walls at points convenient to each ward; they discharge into iron sifter bins, carried on wheels, and placed outside under the outlets of the shoots. These can be wheeled away when required, and empty bins substituted. The openings to these shoots are protected at the inlets by horizontal iron cross bars, and have stout iron quadrant receivers, formed to shut flush into the wall when not in actual use, and to be so locked by the attendant.

Throughout the asylum thorough provision has been made for the suitable placing of supply pipes for gas and water, but the source of these necessities must depend upon the special conditions and surroundings of the site.

Fireproof floorings and ceilings are used in the wards and in all parts occupied by patients, also in the main administrative block at the north front. All staircases and passages are fireproof, except the staircases in the administrative block. Hydrants with all proper fittings and high-pressure fire mains thereto are provided within and without the building at all necessary points.

The cubical and superficial contents of all wards, day-rooms, dormitories, single rooms, and attendants' rooms are regulated in strict accordance with the published "suggestions and instructions" of the Commissioners in Lunacy; indeed, care has been taken to adhere closely to these in all the arrangements and details of the design.

Whilst ward accommodation is in this plan calculated for 310 patients, the administrative portion is designed to accommodate 450 patients, thus providing for convenient future extension. Plans have been drawn for the addition of such extensions, and, keeping these in view, the low portions of the epileptic wards are in the original plan provided above with proper fireproof floors, so that they would be ready to receive the additional storey at any time without uncovering the ward beneath. The adding of this upper storey in the first instance would provide additional accommodation for 50 patients at an extremely slight increase in the original cost.

The character and style of building is indicated by the perspective view. The walls are of brick, the cornices and dressings generally being of stone. Effort has been made to procure a simple but effective and substantial

appearance, without involving undue expenditure in this respect.

Plans have been prepared of the following necessary supplementary buildings, the positions suitable for which would vary upon different sites:—

An isolation hospital affording accommodation for eight patients, with day-room, attendants' rooms, kitchen, &c., complete. The building is so arranged that if patients of both sexes were under treatment at the same time they would be kept thoroughly apart.

Farm buildings suitable for an asylum of the size now proposed, with cottage for the farm bailiff. A mortuary, with accommodation for visitors, and a post-mortem room.

A porter's lodge with weighbridge.

The total cost of carrying out the design complete in every respect (excepting only laying out of grounds) is estimated at £45,000. Quantities have been taken out, and a contractor has expressed his readiness to carry out the work thoroughly and well at that price. The estimate includes the supplementary buildings just enumerated and also numerous items which it has not been considered necessary specially to mention in the above description, *e.g.*, boilers, engines, laundry machinery, cooking and baking apparatus, fencing for estate and airing courts, and shelters for the latter.

If the asylum were erected for 310 patients only, the cost per bed would be £145; this figure would, however, be materially reduced if the building were erected in the first instance for a larger number. Within certain limits, the smaller the asylum the greater must be the cost per bed. For a thoroughly complete and efficient asylum of the size now proposed, with so much provision for future extension, £145 per bed is certainly a low figure, especially when the following points are taken into consideration: fireproof construction of flooring, ceilings, passages and staircases; an elaborate system of heating and ventilation, providing for the introduction to all wards of warmed fresh air and the due extraction of that which has become vitiated; separate pavilions for all w.c.'s, urinals, lavatories, &c.; a drainage system constructed in strict accordance with that advanced knowledge of the subject which is of comparatively recent attainment; the subsequent economy of administration which would result from the compactness of the buildings and the combined separate and thorough communication to

and between the wards. These various advantages are not possessed by asylums which are cheaply erected at a low cost and are then found to require numerous alterations and additions. The provision of heating apparatus, improved sanitary arrangements, rain-water collecting system, &c., subsequent to the erection of an asylum, is far more expensive and less satisfactory than if these be included in the original design. All details and arrangements in the present plan have been thought out with much care; a full description of the minor points which have been considered would be impossible within the limits of the present paper, but it is believed that the result attained is such that practically no alterations or additions would be found to be necessary if the design were carried out in its entirety.

I wish to express my indebtedness to Messrs. Berry and Burmester for technical descriptions appearing in the above paper.

On a Recent Visit to Gheel. By D. HACK TUKE, F.R.C.P.

Having availed myself of the opportunity afforded me of visiting Gheel a second time when attending the Psychological Congress at Antwerp in September, I propose to describe this remarkable insane colony, as I think it cannot fail to suggest important questions and considerations, in regard to which much difference of opinion still exists.

The visit to Gheel formed one of the excursions arranged for by the Belgian Society of Mental Medicine, which originated the Congress. We left Antwerp on the morning of the 10th of September, and passing Lierre and Herenthals, we arrived at Gheel, which is about 25 miles east of Antwerp, in about an hour. Among our number were Dr. Eames, Dr. Rutherford, Dr. Pritchard Davies, and Dr. Stanley Elliot, and I hope their views of Gheel will find expression as well as my own. It is the largest village or town in its district, the Kempenland or Campine, and has a population of 5,000, or, including the surrounding hamlets, 11,000 inhabitants. There are 3,025 houses, of which 1,100 receive lunatics, or above one in three.* The area covers 26,000 acres, and has a circumference of 24 miles. I mention these details because they will convey a correct idea of the extent

* The number of "hôtes," those who take charge of paying-patients, is 160; the number of "nourriciers" those who take charge of the indigent, is 1000.

of the district, which is the seat of a colony of lunatics numbering over 1,600. There are, in fact, at the present time 1,653 patients, including those in the asylum, or above one in seven of the inhabitants. The population is mostly agricultural, not a few, we may hope, having attained to the coveted possession of "three acres and a cow."

M. Oudart, the Inspector-General of the Asylums of Belgium, went with us; and Dr. Peeters, the physician-in-chief, having met us at the station, led the party at once to various houses in which patients are boarded. The Burgomaster also accompanied us, and I may here state that the Government of this colony is vested in a Commission consisting of the Burgomaster, in addition to the Governor of the Province (the President), the King's Procurator of the Court of First Instance of Turnhout, the Justice of the Peace of the Canton, a medical man appointed by the Government, and two members chosen by the Minister of Justice; in all, seven. This Commission meets at least once a quarter, and makes a general inspection of the patients, the houses in which they are living, and the asylum, a report being drawn up and presented to the Ministers of Justice. I may add that there is also a "permanent Committee," which sees to the boarding-out of patients on their arrival, has the oversight of those who take charge of the patients, and also receives and pays monies.

Returning to our visitation of the houses in Gheel, I should state that Dr. Cuisenaire, one of the medical men placed in charge of the colony, informed us that it is divided into two sections, and that over each is placed a medical supervisor and his assistant. I understand the rule to be that each patient must be seen at least twice a month, the curable being visited every week. Four hundred patients are, it will be seen, placed by this arrangement under the more immediate care of one medical man, in addition to the general inspection of Dr. Peeters, who resides at the asylum; and, further, under these sectional physicians, there are six "gardenes," or what may be called visiting attendants.

Some of the cottages we visited were no doubt of a very humble description, and would be very far indeed from coming up to our ideas of comfort; quite the reverse. But it must be remembered that a large number of the poor who go to Gheel as patients have not been accustomed to much, or, indeed, any, better dwellings. In one cottage into which we entered there were two female idiots and a dement. The former were provided with pierced chairs in the room in

which the family lived. A woman in charge looked kindly, and there was no reason to doubt that they were well-cared for. I was more disposed to pity the people of the dwelling for having idiots of dirty habits in the room where the meals were taken. I ought to say that the beds, though somewhat of a primitive character, were clean; and if the day we spent there was not an exceptional one, and if what we saw was a fair sample of the attention paid to patients who cannot attend to their own wants, a tolerably satisfactory answer might be given to the question which at once arises: Is proper attention likely to be given to this numerous class in these cottages? I should have thought that such attention is much less likely to be given in cottage than in asylum care. Dr. Peeters recognises the difficulty, but he asserts that many of these patients are cared for at Gheel in an intelligent and devoted manner. An able Belgian physician, M. Lentz, whose excellent asylum at Tournai we visited, says: "To place those of dirty habits in the family of a caretaker or nurse is to remedy every inconvenience. It is to abolish a quarter in an asylum which always presents a repugnant appearance, while it insures the patients having those hygienic conditions and care which no asylum can afford."

This conclusion will hardly meet with general assent, and I fear that a more intimate acquaintance with the cottages in Gheel would fail to support it.

Another house we entered was an *estaminet*, and here there were two insane women, one of whom was quite tranquil, but the other was restless. They were under the charge of a *nourricier*. Into the room they occupied (the back-parlour) men would drop in every now and then to drink their glass of beer, or play at cards. Of course, this sort of thing seemed rather odd to us, with our old-fashioned notions; and, indeed, one could hardly help thinking that it would have been as well to avoid the use of beer-houses in the boarding-out of patients. The difficulty in regard to drink arises also from the liberty granted generally to the insane patients in Gheel to enter public-houses. Dr. Peeters says: "Article 92 of the Regulations has for its object to prevent abuse and excess, but it is not as rigorously observed by our *nourriciers* and by the retailers of liquor as it ought to be. I am obliged to add that the local police also are too indulgent" ("Gheel et le Patronage Familial," 1883, page 139).

In the inn at which we were hospitably entertained after

visiting more cottages occupied by patients, was a British youth, who went by the name of "John." For this patient's board, lodging, and care, £60 per annum was paid. He seemed happy, and certainly had ample liberty allowed him, for in the evening he went with several of us to the railway station after 10 o'clock, leaving us to return to his quarters quite alone; and here one cannot help remarking that several serious questions arise in considering the location of such a youth at Gheel. Here was what appeared to have been a case of pubescent insanity, which had drifted into mental weakness. One could hardly think that he was as favourably placed as he might have been for medical treatment; nor was the moral environment just what one would have chosen. Then, again, there was the distance from home and friends. That a young man can be, and is, thus expatriated is surely a serious matter, and the question may, with advantage, be discussed by us, whether British subjects, should be sent without their will into foreign countries and deprived of liberty in even the minimised form that we witnessed at Gheel, without some authorization by the Government, or, at least, without some notice having been given of what has been done. I think the fact that I have mentioned goes far to support the resolution which was adopted by this Association very recently in regard to British subjects labouring under insanity and placed in asylums abroad. On the whole, the houses into which we went were adapted to the social classes for which they were designed, the poor and the well-to-do. We saw an English gentleman who was one of two patients in a comfortable house. He was an architect by profession, and had made some very good water-colours of the church and other objects of interest at Gheel, which we should have been glad to bring away with us, but unfortunately the artist set an extravagant value upon his productions. He paid for his accommodation, &c., only 50 guineas a year, and had (to say the least) as much as could be expected for so small a sum. He was unmistakably insane, and held forth on the evils of Gheel; but, at any rate, he could not complain of undue restrictions on locomotion, as he appeared to go about just as he liked, and accompanied us in our peregrination and visits to the houses. Indeed, this was one of the oddest features of this odd place, that a patient who would in all probability have been, if in England, confined to an asylum, could go about the town at his own sweet will, and could, for instance, sit down

in the most unceremonious manner in the room of the villa occupied by an English lady into which we went. Of this lady patient I may say that she was in comfortable rooms, with a nurse, and paid a very moderate sum. Whether she might not, from her point of view, complain of the invasion of her room by the gentleman patient as well as our own party I will not say. Here again the question arises, Why is this patient sent out of England among strangers? One reason, no doubt, is the low charge; another, perhaps, that she may be out of the way, and avoid the publicity consequent upon her treatment in England, and possibly the third reason may be an honest desire on the part of the friends to avail themselves of the alleged advantages of the outside asylum life found in such perfection in Gheel.

The best furnished house into which we went, and one having a pleasant garden attached to it, was under the experienced charge of the daughter of the late Dr. Bulckens, who was physician-in-chief at the time of my previous visit. Here there were three patients, gentlemen, one of them a Polish Count, who pays only £160 a year, and the others paying £140 each, making a total of £440 per annum. It will, therefore, be seen that the friends of patients can obtain for them good accommodation on very low terms. The highest sum received at the present time is £200 a year.* As to the payments made on behalf of the indigent patients, of whom there are about 1,460, Dr. Peeters explained that these patients are divided into three classes, the clean, the dirty, and the semi-dirty. The first pay 8d. per diem, of which 6d. goes to the nurse for board. Inasmuch as many of this class work in the fields, &c., they get extras, which consist of small monies, beer and tobacco. The second class—the dirty—pay 10½d. per diem, of which 9½d. goes to the nurse. The third—the semi-dirty—pay 9d., of which 7d. is apportioned to the nurse.

The sums paid to the people in Gheel amounted in the course of last year to £28,800, which is at the rate of about 6s. 8d. a week per patient, while the receipts from patients amounted to £31,360, leaving a balance of £2,560.

In connection with these figures I must observe that to the Belgian authorities, Gheel presents itself as a most practical question of financial economy. There were on the 1st day of

* The usual scale of payments per annum for the non-indigent is as follows:—£16, £20, £24, £28, £32, £40, £48, £80, £96, £120, £144.

January of this year in the asylums of Belgium 8,986 lunatics. Now it is contended by M. Oudart, the inspector whom I have mentioned as being with us during our visit, that of this number 2,000 might be placed in colonies like Gheel, or with their friends. If this were done room would be made in the present institutions for those who really require asylum care, and it would be unnecessary to provide new asylums estimated at a cost for construction of £140 per head, or a total of £280,000; to which must be added the outlay for furniture, and also the difference in regard to maintenance between asylum and cottage care, for while at Gheel this averages 8½d. per diem for an ordinary case, it amounts in a Belgian asylum to 11d. a day; so, that in this item there would be a saving of no less than £6,000 annually. From this, the mere £ s. d. aspect of the question, one could not but feel that the Belgians were justified in defending the cottage system of the care and treatment of a large number of their insane population.

For well-to-do patients, and especially for any lady or gentleman leaving a comfortable home, say in England, a residence at Gheel would have, it must be admitted, no inconsiderable drawbacks, for at best it is a dull place, and in winter it must be bleak and uninviting in the extreme. There is a marked monotony about the streets, in which few people are to be seen. Then, as there is no gas, the scant light afforded by oil lamps in the evening is not a little depressing. If Sydney Smith was right, as no doubt he was, in insisting on the importance of abundance of light to dispel mental darkness, Gheel cannot be commended in this particular, for the houses as well as the streets must be decidedly gloomy during the evenings of half the year. The streets and the square of the town have been described by a recent traveller as saturated with water and in a horribly dirty condition when he visited the place. "The space in the middle of the square," Dr. Tucker says, "was ankle deep in mud, and the first object which specially attracted my attention was an old insane woman wading pensively about through the deep cold slush." This, however, was in winter, on a cold day, and in a heavy fall of rain. On the two occasions I visited Gheel the weather was fine, and the foot-paths were not muddy, although very dusty. The main streets are paved. Every one knows how much the state of the weather affects the impressions received in going over a house "to let," and I think that the very unfavourable conclusions this gentleman arrived at in regard to the comfort of the

patients at Gheel were somewhat intensified by the bitter wind that was blowing, and the heavy rain that was falling, on the December day, when the cold penetrated to the very bone, in spite of the capacious ulster which he wore when I had the pleasure of meeting him. And I would here say that although I did not leave Gheel on either occasion with any enthusiasm for the system pursued there, I am satisfied that it is carried out with the best intentions, that the present medical head is humane, and, moreover, quite willing to admit, nay, more, to urge, that there are serious defects in the carrying out of the system, and that Gheel is not by any means a Garden of Eden. On the other hand he would not think (nor should I) that "the trail of the serpent is over it all." There may be some asylums, even in England, where life is almost as dull as at Gheel, and where the look-out is almost as monotonous, although, on the other hand, it must be maintained that in favourably-situated and in well-conducted asylums there would be more means of amusement and mental occupation for a gentleman or a lady patient, and, indeed, for the pauper class, than can be provided at Gheel. This brings me to speak for a moment of the employment of the patients in the Gheel Colony. It has been found possible to employ both sexes to a considerable extent. The figures given by Dr. Peeters show that 72 per cent. are engaged in some kind of occupation. Nearly 400 men are occupied on the farms and in the fields, also about 100 women in the same manner, while the number of the latter who work indoors is much larger. Dr. Peeters speaks with satisfaction of the number of general paralytics employed out of doors and the advantage derived from their employment: "The quiet life in the fields, breathing the pure air, and the regulations of the functions by physical exercise, have arrested the course of the disease." Some patients are employed as masons, and others as painters, shoemakers, carpenters, tailors, while a few women are engaged in making lace. Dr. Peeters justly takes for his guiding principles as to what is right in regard to quality and quantity of work: Occupation, yes; fatigue, rarely; overwork, never; and that all service merits remuneration. Many of the men, and some women, receive small sums of money on a Sunday, and the caretaker is obliged to give it in all cases in which the patient can make proper use of it. Tobacco, beer, sugar or cake are also given.

We, of course, made inquiry whether the large amount of

liberty enjoyed at Gheel led to a large number of homicidal and suicidal acts, or to illegitimate births among the insane females. It appears that since 1850 no successful homicidal act has been committed at Gheel, but in 1878 a patient made a violent attempt to injure the daughter of his caretaker. Again, there have been fires from time to time at Gheel, but since the above date no patient has been known to take any part in their production. With regard to suicides they have been rare, and Dr. Peeters confidently maintains that a comparison between the statistics of suicides, homicides, and acts of violence in asylums with those which take place in the Colony at Gheel would tell vastly in favour of the latter. Then in regard to illegitimate births, Dr. Peeters informed me that during the last 10 years there had been three or four. In regard to one of them it is much to be regretted that so natural a result was not anticipated and prevented. A female patient was removed from an asylum, known to have erotic tendencies, and was sent to Gheel. There she was placed, not in the asylum on trial, nor alone in a peasant's house, but in the same house as an epileptic patient, both being of the most troublesome class, free pensionnaires. The consequence was pregnancy, and on the arrival of the child infanticide, the only incident in the story which one cannot regret. Dr. Peeters was called upon to make a medico-legal examination, and arrived at the conclusion that she was not responsible, and that it was necessary to place her in an asylum. That such a scandalous case is altogether exceptional, one must believe, or the system at Gheel would surely be condemned to extinction by the popular voice, which for once, at least, would be *vox Dei*.

Here it ought to be stated, as bearing immediately upon the infrequency of violent acts or offences against public decency, that Article 17th of the law regulating the colony at Gheel makes some very important exceptions to the general principle that the insane of all categories may be admitted, for it excepts those for whom continuous restraint is required, suicidal patients, homicidal patients, incendiaries, those likely to escape, and those disposed to disturb the tranquillity of the community, or to shock public decency. It is most important, in judging of Gheel, to be aware of these conditions, for if stringently carried out they must greatly facilitate the success of the system. It must, however, be evident to any one acquainted with the various

phases of insanity that it would be impossible to guard entirely against the development of any one of these dangerous conditions. Indeed, the opinion we form of the practicability of establishing such a colony as Gheel greatly depends upon whether we consider it consistent with what we know of the instability of the insane brain, that some 1,600 patients can be collected together in one locality, none of whom will injure themselves or others, nor wander away, nor disturb the tranquillity of the village, nor ever shock public decency.

I may here refer to the extent to which mechanical restraint is resorted to at Gheel. We have seen that patients are not to be admitted to the colony who require constant restraint, and in the houses we visited we did not happen to come across any patient in a strait-waistcoat. To use it, special leave must be obtained, a check which Dr. Peeters thinks must render abuse impossible. In addition to the camisole, the belt, with or without gloves, and straps by day or by night are employed. "All asylum physicians know from experience," says Dr. Peeters, "that complete non-restraint is a dream, the full realisation of which is impossible." * In regard to seclusion, Dr. Peeters says, "a caretaker may, under certain circumstances, be obliged to shut up a patient in his room, but only temporarily. Patients requiring seclusion must be sent to the asylum."

Of the asylum itself at Gheel a very few words will suffice, seeing that the interest of the place does not centre in it, but in the cottages in and around the town. I will merely say that it appeared to be a well ordered institution, and that there were 60 patients. When I was at Gheel in 1862 it had just been opened, and the wonder is that it had not been built long before, for if a colony like that at Gheel is to succeed at all, it must be supplemented by an institution for observation and for the admission of cases from the village which have become unmanageable. It is worthy of note that Esquirol proposed to the Minister of the Interior of the Netherlands, after his visit to Gheel in 1821, that an asylum should be built into which those patients who from their excitement or dirty habits were the most liable to be badly treated by their hosts, might be admitted, while the director, the doctor, and the superior officers of the asylum should exercise an active and constant supervision

* "Gheel et le Patronage Familial," page 33.

over all the patients in the country houses. It will be seen that this wise counsel of Esquirol was not followed until about 40 years after it was given.

No notice of Gheel would be complete which omitted a reference to the Church of Saint Dymphna, a large Gothic building erected in the 14th century, and dedicated to the patron saint of the colony, whose history may here be read in carvings in oak and stone and in paintings, one of which represents the healing of the first lunatic through her miraculous influence.

It was in connection with the foundation of this church that a Pope, Eugene IV., issued in 1400 a Brief which ran thus :—

“ When, therefore, as we understand, a great number of faithful Christians have flocked together for the purpose of special devotion to the Chapel at Dymphna on account of the many miracles which Almighty God to the merit of this virgin vouchsafed to perform, and also when many vexed with evil spirits were wont to be carried thither, but that they might be delivered from them,” &c., &c.*

I think no one can visit this edifice without being better able to realise the singular event, which, if we may trust tradition, originated 1,200 years ago what we now witness at Gheel. The legend should interest us more especially as the personage who unwittingly brought the Colony of Gheel into existence came from the British Isles. There lived at that time an Irish King whose conduct towards his daughter Dymphna afforded her good reason for escaping from him. She had also good reason for supposing that in the lonely district of Batavia to which she fled she would be able to remain undiscovered and unmolested. To this spot, however, her father tracked her and her confessor Géréberne, who accompanied her in her flight. The King decapitated his daughter, and his soldiers murdered the priest. It is rather too late now to inquire whether there may not after all have been two sides to the question, and those who care to exercise their ingenuity in whitewashing Henry the Eighth

* M. Gife, an architect, states in a work published by a literary society of Turnhout, that there was in even the seventh century a chapel on the site of the existing church, dedicated to St. Martin. He gives the date of the building of the church of St. Dymphna as the 12th century.

and Mary Queen of Scots, may do the same for the British chieftain of the seventh century. Confessor and maid are now and for ever enshrined in the hearts of the community of Gheel, and the church which we visited, under the guidance of a most intelligent and obliging priest, not only tells the story of her martyrdom, but preserves her bones with pious care. Under the large tomb or cenotaph in the church there is sufficient space for a person to pass kneeling, and to perform this ceremony formed part of the duty of the possessed or distracted patient who came to the Church of St. Dymphna to be healed.

But why, it may be asked, did *lunatics* flock to this locality? It was natural, in the first place, that Christian pilgrims should in those days be attracted to a spot hallowed by the blood of a saint who had died at the hands of her pagan sire, and expect to be cured of their diseases. The blood of the martyrs is, we are told, the seed of the Church. In this case it proved to be the seed of an insane colony. Among those who were healed it so happened there was a lunatic, and so striking a circumstance may well have led the friends of other lunatics to bring them to the same place. This, at any rate, is as consistent and probable a story as we can construct out of the mixture of truth and fable of which the early history of Gheel is composed. I may here add that every year in the month of May this tradition is kept alive by a fête in honour of the Saint, when a very large number of persons assemble, sané and insane, to take part in it.

A door in the church opens into a room called in Flemish the *Ziekenkamer* (chamber for the sick), formerly in constant use for the special spiritual treatment of a lunatic. It is one of two rooms about 14ft. square, and is really a stone floor kitchen, at one end of which, against the wall, is a bedstead, to which an iron chain has been attached for restraining the patient during the night, but is not, we were assured, used now. By the side of the fire-place are several iron rings, to which the patient's chair and not the patient himself is secured. This room is still occasionally used. When I visited it in 1862 I was told there had been a patient treated in it *secundum artem* not long before, and Dr. Peeters informed me during my recent visit that there have been on an average about six patients *per annum* treated in this room during the last 20 years. At the time when Esquirol was at Gheel he found that the cures from the

miraculous influence of St. Dymphna were becoming rarer every day. His description of the treatment pursued is as follows :—"A patient on his arrival was placed for nine days in a house adjoining the church, along with a few others, in a room under the guard of two old women. A priest came every day and performed mass and read prayers to them. Then those patients who were tranquil, joined by some children of the place, went three times in procession outside and as often inside of the church during the nine days of treatment. Each time they arrived at the tomb of the Saint they prostrated themselves and passed under it on their knees. If a patient was too furious to allow of this being done, an inhabitant of Gheel and some children were paid to perform the ceremony."

This spot where so many persons supposed to be possessed of evil spirits were exorcised by priestly rites is still interesting to us historically. It is the representative of the ecclesiastical treatment of mental disease. Here was concentrated a force which in the hands of a powerful Church, assisted by all that could appeal to the imagination, worked upon by the romantic history and the miracle-working relics of a martyred saint, was certain to produce an immense effect upon at least some distracted minds, and even in a few instances to dispel altogether the cloud resting upon them. And if the power of the Church in exorcising madness has, here as elsewhere, passed away, we may well recognise the powerful and legitimate influence exerted by moral remedies, including strong mental impressions, in the treatment of insanity. The psychological physician knows that his medical treatment is not bounded by what the Apothecaries' Hall can give him, and by no means excludes this, the moral class of remedies, although he may not be able to arouse so enthusiastic a faith in Psyche as in St. Dymphna. If Dr. Yellowlees is successful in a very intractable form of mental disorder by surgical means, it must be remembered that he accompanies them with such a tremendous dose of moral advice that one feels it is quite possible the latter may be the real factor in the cure. Let Medicine then learn from the past history of Gheel that under the guise of superstition, are often concealed potent influences for good which when correctly labelled may be legitimately employed.

If such be the lesson taught by the ancient history of Gheel, what, let me now ask, is the practical lesson which

we may learn from the condition of this colony at the present day? Nothing can be more natural than the demand made in England for some cheaper means of providing for pauper lunatics than that afforded by our County or even the Metropolitan District Asylums. The new asylum to be erected in Middlesex will involve a most serious outlay, and the third colossal asylum for the West Riding of Yorkshire will entail a cost of at least £189,000, and so on. Whether not only workhouses but cottages are utilised to their fullest extent may be fairly doubted. As regards the former, I believe that if the dietary be that allowed for the aged and infirm as recommended by the Commissioners, they might be used advantageously to a greater extent for incurable patients. Indeed, we know from the returns of the medical superintendents themselves to the commissioners that in their opinion some 4,000 patients might be properly transferred from lunatic asylums to good workhouses. As to the boarding out of pauper patients, I think that the further extension of the system, though it may be desirable, requires great care, and this I say almost more in the interests of the sane than the insane themselves. In the last Report of the Lunacy Commissioners it is stated that, at the Sussex Asylum, seven idiot boys are boarded out in adjacent cottages, and that 62 patients had been removed from the asylum during the year, either relieved or not improved, to workhouses or to the care of their friends. Of these, 50 have been able to remain out of the asylum. Unfortunately we do not know the other side of this apparently successful movement, but if the families to which these patients are restored are not rendered uncomfortable or morally deteriorated in consequence, and if the Sussex workhouses are well conducted, surely this is a course to be commended and to be followed in other counties to as great an extent as possible.

We find from the last report of the English Commissioners in Lunacy that there were in England and Wales 5,896 pauper lunatics on January 1, 1885, living with relatives or friends, or boarded out in private houses, which gives a ratio of not more than 8·28 per cent. to the whole number of pauper lunatics. Very few of these, however, are living with strangers, so that we cannot compare this proportion with that which is found in Belgium (namely, 22 per cent.), where we are simply dealing with patients boarded out in private houses. Dr. Lockhart Robertson holds, as we know,

that it is an unjustifiable waste of public money to place more than 50 per cent. of pauper lunatics in asylums, but we have at the present time 67·45 per cent., and it may be added that the proportion living with relatives or others was 18·24 per cent. in 1859, as against the 8·28 which I have already given as the proportion per cent. at the present time.

It has been said again and again that Scotland already presents an example of the system pursued at Gheel, but this is only true in a modified sense. People turn to the Report of the Scotch Commissioners in Lunacy, and say there are 1,861 pauper patients (or 20·3 per cent.) in private dwellings (exclusive of 130 private patients), but then it will be found that only 926 (or 10 per cent.) of these pauper patients are boarded out with strangers as at Gheel. Persons speak of Kennoway, in Fifeshire, as the Scotch Gheel, but the number of patients is so limited, and the place itself on so small a scale, that it cannot be compared to the Belgian colony. We were fortunate in having Dr. Rutherford one of our party, for no one could tell us better than he the points in which Gheel differs from the system carried out in Scotland. He was struck by the very different class of cases treated in the two countries in cottages, those in Scotland being only of a chronic demented class and these paupers, whereas at Gheel, as we have seen, there are patients in various stages of insanity, curable and incurable, and persons high in the social scale. Some of the cases we saw would have been undoubtedly placed, and properly placed, in an asylum in England. On the other hand we saw patients in some of the Belgian asylums who would have done very well elsewhere, and who, in Dr. Rutherford's opinion, would have been boarded out in Scotland. It was his opinion also that the boarding-out system is more systematized in Scotland than in Belgium, and is more intelligently supervised. I have already stated the kind of supervision carried out at Gheel; with this would correspond in Scotland the quarterly visits of the parochial medical officer, who makes a written report on each occasion; the opinion of the medical officer of an asylum that the case is suitable for cottage treatment; and lastly, the periodical recommendation which the Commissioners in Lunacy think proper to make.

There is another point of contrast between Belgium and Scotland, in their cottage treatment of lunatics, and this has

reference to the large number of patients concentrated in a comparatively small space in the former country; a number, according to Dr. Rutherford, which would be spread over 200 square miles in Scotland.

These differences are very important, and it is quite clear that the Scotch system may succeed where the Belgian fails. Many think that the Scotch system is not altogether a success, and certainly if we entertain misgivings as to *its* advantages, we must entertain still greater misgivings as to the planting of a Gheel in this country as one of the means of providing for our fearful accumulation of pauper lunatics.

Dr. Fraser says in the last Report of the Scotch Commissioners: "The increase of boarded out patients is not in my opinion due to Scotland's being specially suitable for the treatment of the insane in private dwellings. This is often, but I think erroneously, said to be the case. Other countries possess retired hamlets and villages, clean and tidy cottages, and thrifty, respectable and matronly house-wives, who would make excellent nurses for the insane" (Appendix C., page 129). There is no doubt much truth in Dr. Fraser's remarks, as also in his statement that segregation, and not aggregation, should be the aim in the treatment of lunatics. "Because treatment in asylums is greatly forced on us, as the best available treatment in the circumstances, we need not shut our eyes to their disadvantages and true nature, and if there is a class of the insane for whom asylums are not necessary, it becomes a duty to endeavour to provide for them in other and more natural ways" (page 131). We may differ, however, as to the direction segregation should take, and may think it should be in the way of providing smaller buildings for distinct classes of cases, rather than boarding patients out to strangers on a very large scale, especially concentrating them in one locality. It is only fair to say that although I have no great liking for employing strangers in the care of the insane, there is strong evidence that the non-related guardians are better than the related ones, partly because the immediate relatives are so often themselves peculiar. This unfortunate circumstance no doubt militates considerably against the otherwise excellent course of removing inoffensive patients from asylums to their homes.

In conclusion, then, I would say that while there is nothing absurd or impracticable in the idea of having a

Central Asylum for the care and treatment of patients, dangerous to themselves or others, combined with the boarding-out in the neighbourhood of those cases who are suited for cottage life, I believe the extent to which this can be properly carried out in any one locality is extremely limited in England. It is a question of degree. The wise and discriminative use of private, as contrasted with asylum care, ought, however, to be kept constantly before us. If one had only to consider the good of the patient, I should not speak of this form of accommodation as so limited in its application as I have done; but I can never dismiss from the consideration of the subject the influence exerted on the family in which the patient is placed. I must think that in a considerable number of cases evil is done to the household in which an insane person is lodged, to say nothing of the crowding of the house or cottage, and the rendering of domestic life less comfortable. On this ground I consider that the greatest possible care ought to be taken to carry out this system without detriment to the family which takes charge of the lunatic. This objection does not apply to cases in which villas, whether at Gheel or elsewhere, are occupied by a patient under the charge of a nurse or trustworthy man and his wife, and we should all wish to see this arrangement develop, in the case of private patients, to as great an extent as possible, provided always there is sufficient supervision.

Again, while the liberty granted to patients in a colony like that at Gheel is very good, and in some instances decidedly better than the restrictions of an asylum (especially one in which the superintendent, in mortal fear of some catastrophe happening, never runs any risks either as to escapes or suicides), yet the liberty at Gheel is, I can have no doubt, abused to a greater extent than appears on the surface. Those who are not blind to the frailties of human nature—insane human nature—will hardly suppose that the great liberty granted to 1,600 lunatics does not lead to a greater degree of evil than finds expression in mere statistics. One of the patients, a Russian, who spoke English very well and accompanied us in most of our visits, went with us to the station in the evening, and said good-bye to us, but what was our astonishment to find him on the platform when we arrived at Antwerp at midnight, his own satisfaction being as great as our surprise. He accompanied Dr. Eames to his hotel, and afterwards to a restaurant, and appeared well

acquainted with the less desirable quarters of the city, with which he offered to make our worthy President acquainted. I have no doubt he returned safely next day to Gheel, but this was a curious illustration of the probable disadvantages, as well as advantages, associated with the well-intentioned freedom of action accorded to the patients of this colony. I have already said that a British youth was with us at the station, and there was no reason why he might not have got into one of the carriages of our train as well.

I may add that the Belgian authorities are themselves so well satisfied with the success of Gheel, that another locality has been chosen for a similar colony.* This is situated at Lierneux, not far from Liège. About 30 have been sent to the cottages there. Some opposition was shown at first to this course, but M. Oudart, the Inspector of Asylums in Belgium, says that now "the inhabitants have become familiarized with the insane since they have seen their conduct, and especially since they have recognised the important advantages which such a colony will bring to them, and the opposition has ceased; in fact, everyone wishes to inscribe their names as nurses." M. Oudart adds: "One ought not to lose sight of the fact that the creation of a colony of this kind constitutes for the nurses and for the commune where it is established, a source of very great advantage."† I see no reference, however, to the disadvantages to the families which must accrue in a greater or lesser degree.

Dr. Peeters, the ardent admirer of the system of "free air for the insane," exclaims in his book, "Foreigners! go and tell your countrymen what has been done at Gheel for the amelioration of the lot of the poor lunatics." ‡

This I have endeavoured impartially to do.

* One of the admitted hardships connected with Gheel is that the Wallon insane sent there are amongst the Flemish instead of their own race. At Lierneux, this disadvantage does not exist (see notice of the Belgian Congress of Psychiatry in "Notes and News.")

† "Des Colonies d'Aliénés," 1884, p. 4.

‡ "Gheel et le Patronage Familial."

CLINICAL NOTES AND CASES.

An Unusually Heavy Brain in a General Paralytic. By T. W. McDOWALL, M.D.

The entire interest in this case lies in the brain weight, but it may be well to record the few known facts about his previous history, and to give a general outline of his condition whilst in the asylum.

A. T., æt. 48, single, engine-fitter; admitted 13th November, 1884. He had been for three months in a workhouse, but was sent to this asylum because he was restless at night and troublesome to his neighbours. As to his previous life-history very little is known. He is reported to have been a hard-worker, a very hard-drinker, and given to sexual excesses. His sister is stated to have been insane, and to have committed suicide.

When admitted he was only the wreck of a once powerfully built man of about the average stature. He was fairly nourished, with florid complexion. The size and shape of his head at once attracted attention. It was a typical dolicocephalic skull, not at all deformed or suggestive of previous hydrocephalus, but of most unusual size. Irides blue, pupils slightly unequal. Appetite good; tongue large and pale. Pulse 60; temp. 97·8. Nothing abnormal in thorax and abdomen.

During examination he lay quietly in bed, but talked incessantly to himself; what he said was incomprehensible nonsense, and typical delusions were not detected. His attention was with difficulty arrested and kept; indeed, he was too demented to understand much of what was said to him, and too busy with his own ideas to pay much attention. There was marked fibrillary tremor of the muscles of the tongue and face. His voice was thick and very tremulous. When the patient was out of bed he was markedly unsteady in his gait, so much so that considerable anxiety was felt lest he should fall and injure himself.

Little need be said about the progress of the case: it was steadily and rapidly from bad to worse. From the first it was occasionally necessary to allow him to lie in bed on account of his restlessness and to prevent injury. He seemed quite unconscious of his bodily feebleness: he smiled when spoken to, somewhat as a half-drunken man does; was delighted if grand ideas were suggested to him; and night and day he often tossed his mattress about in search of gold. In a short time he was too feeble to stand unsupported; indeed, about 10 days after admission he seemed to have a congestive attack, which permanently damaged the right side. Progress downwards

was rapid; bed-sores appeared, and he died on the 23rd December. For a few days before death it was suspected that he could not see. This was probably true, as the post-mortem examination disclosed such an unusual amount of fluid in the head.

The above is a brief abstract of the notes of this case, which, beyond the brain weight, presents no feature of interest. It was an ordinary one of general paralysis in the beginning of the last stage, and it failed to pass through the usual phases by being cut short through the excessive accumulation of fluid in the cranial cavity.

The following are the post-mortem notes, slightly abbreviated:—

Head.—The skull of unusual size, decidedly thickened and dense. Skull-cap firmly adherent to dura mater; dura mater adherent to pia mater here and there. Eleven ounces (by measure) of fluid escaped during removal. The membranes over upper and lateral surfaces so thickened, swollen, and opaque that the convolutions are invisible. This condition of the membranes is continued along the Sylvian fissure. Brain in ordinary state, =61 oz.; drained of all sub-arachnoid fluid, =58 oz. The convolutions are everywhere much atrophied; sub-arachnoid effusion abundant in usual places. Vessels at base distinctly atheromatous; the chief branches in same state. On section: Grey matter pale and shallow; the ventricles very large; the lining membrane markedly granular. No trace of softening or clot.

The notes relating to the viscera are of no interest.

This brain is the heaviest I ever saw, and may be compared with the weights given in most text-books of anatomy, in Clapham's papers on "Brain Weight in the Insane," and elsewhere. The 11oz. of fluid which escaped during removal without doubt represented some ounces of brain tissue. If, therefore, we add, say half, $5\frac{1}{2}$ oz., as representing the tissue lost during the progress of the brain atrophy, we arrive at $66\frac{1}{2}$ oz.—perhaps the heaviest brain weight ever recorded.

Two Cases of Melancholia. By ALEX. PATTON, M.B., Farnham House, Finglas. (See "Notes and News.")

I desire to place on record two cases of melancholia, in which the exciting cause of the disease under which each laboured being the same, the progress and termination differed very widely.

I.

The first is the case of a married lady, R. L., æt. 32, mother of four children—a healthy, active woman, of quiet domestic habits, who, from some unexplained cause, had the misfortune to suffer in her last

confinement, a few months before, a complete laceration of the recto-vaginal septum, obliterating the perineum and leaving one common cloaca. This accident and its accompanying annoyances weighed heavily on her mind, she became very desponding and melancholic, and attempted suicide more than once.

She came under my care in the month of May, 1879, presenting a very discouraging aspect, the gloom of the prognosis being increased by the fact that a brother had been under my care some years before suffering under suicidal melancholia, from which, however, he ultimately made a hopeful recovery. Strict insistence on nourishing diet and close watching had a good effect in restoring this lady's bodily health, but the continued absence of the catamenia for some period led to an examination of the state of the womb, when it was discovered that the posterior part of the os and cervix uteri was deeply eroded, having possibly suffered laceration at the same time with the other accident.

Repeated application with solid nitrate of silver was followed by the gradual filling up of the sulcus, the parts around assuming a healthier appearance, but all the time the patient remained in a very depressed and desponding state.

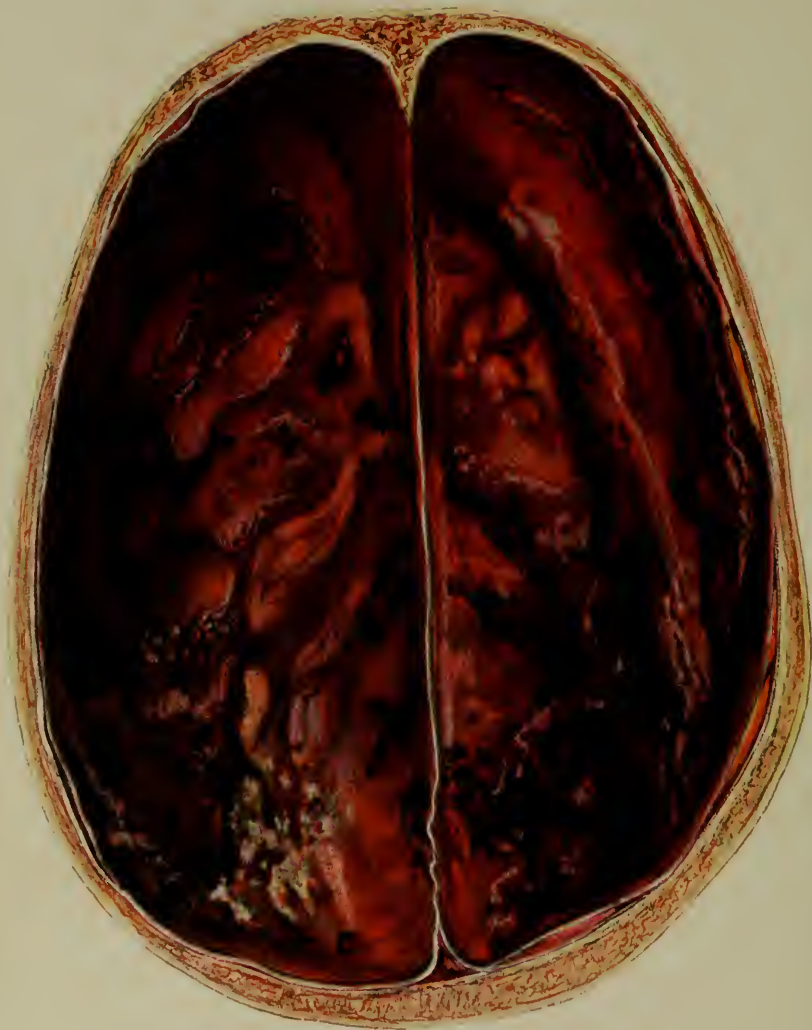
Some eight months after admission, four or five from the commencement of the local treatment to the uterus, and a few hours subsequent to an application of the caustic, a violent attack of hæmorrhage came on, producing faintness and exhaustion and requiring to be controlled by the tampon. From that time—and this is the point to which I desire to call particular attention—mental improvement commenced, the melancholic depression was succeeded by brightness and cheerfulness, she asked for work materials, read, and employed herself, and her convalescence was so established that after two months more she was able to return home, resumed her position in the household, and has since been made the happy mother of a healthy baby. Of course no attempt has been or can be made to restore the obliterated septum.

II.

The second case was that of A. S., æt. 31, a married lady, mother of three children, who after her last confinement, about six months ago, suffered from recto-vaginal rupture, which did not, however, extend to the sphincter ani, and was operated on about a month previous to her admission, with partial success. She became very melancholic, though not suicidal, allowed her mind to dwell continually on her ailment, became utterly unmanageable at home, and was sent to this asylum in April, 1884.

Her history previous to her marriage was that of one given up to amusement, dress, and self-indulgence, and after marriage she so continued—never having been known to take a needle in her hand or help in any way in the management of her children.

When admitted she was pale and sallow, badly nourished, crying



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INTERIOR OF CALVARIUM
ILLUSTRATING CASE OF HÆMORRHAGIC PACHYMENINGITIS.

over herself, and utterly abandoned to perpetual and open masturbation, on which bromides, baths, syringing, or the presence of persons about her, produced no restraint.

She refused food, and had to be fed and nourished artificially for more than a month, her health needing extra nourishment and stimulants, as a large abscess formed between her shoulders, which after discharging about a quart of thin pus healed up. Her health of body recovered, but her mental condition remained the same, with at times an exaggerated idea of her own misfortune. Her habits were filthy in the extreme, and she paid no attention to the calls of nature.

The need for artificial feeding ceased after a time, and she ate ravenously, which still further strengthened her body, but no mental improvement followed. Her disgusting habits continued, and I was obliged to ask her friends to remove her to another asylum, where she still remains pretty much in the same state, a great contrast indeed to the happy termination of the first case reported above.

Case in which Hæmaturia and appearances as of severe bruises occurred spontaneously in the course of an attack of maniacal excitement, and in which after death there was found to be extensive internal hæmorrhagic pachymeningitis. By GEO. H. SAVAGE, F.R.C.P., and R. PERCY SMITH, M.D. (With Plate).

J. H. M., commercial traveller, married, age 40. Sister insane; no family history of hæmophilia. First attack of insanity, cause unknown. Habits sober. General health has been good. Has been subject to hay-asthma. Never had hæmaturia, and was not known to bruise easily. He has been a steady, industrious man, with studious tastes, yet of cheerful disposition. Ten days before admission had a pain in back of head and neck. He then became emotional and depressed, and the same evening was restless. This restlessness passed rapidly into mania.

The medical certificates said he believed his wife was insane; that the nurse wanted to poison him; and that he had waded through the shining river. He became incoherent and violent.

On admission into Bethlem Hospital he was so restless, violent, and weak that he was placed in the padded room. He rolled about, was sleepless and noisy. He was wet and dirty. Bowels relieved by white mixture. Temperature 99°. Heart and lungs normal. Tongue dry and brown.

On the day after admission he passed eight ounces of blood and urine, the proportion of blood being large. He passed urine on several other occasions with no signs of blood. It was noticed and reported that on admission he bore many bruise-like marks on arms, fore-arms, and over ribs.

He refused food, and had to be fed by means of the stomach pump. Three days after admission urine was drawn by catheter, and was free from blood. Temperature 101°.

It was now noticed that the bruised appearances were larger and more numerous. He was still restless and excited. Stimulants were given, and lemon juice with his food.

The question now arose as to the cause of the bruise-like patches, and with it the probable origin of the blood in the urine.

On July 25—a week after admission—it was noticed that the patches were symmetrically disposed, and some were so placed that no ordinary bruises could arise in the situation. These bruises were largest over the anterior spinous processes of the ilia, over the sides of the gluteal regions, around the knees, and over the shin bones, where they occupied the usual sites of erythema nodosum. They were present, too, about the elbows and the arms. They appeared in the night, and in the course of a few hours they were bronze, like the colour in advanced Addison's disease. The patches were very variable in size; some were several inches across, while others were only about one inch square. On one occasion two or three spots like flea-bites were noticed, but these disappeared by the next day. Where the patches occurred the skin was in no way altered in thickness, nor was there evidence of any subcutaneous change. The nature of the eruption, its symmetry and its misleading aspect, render it important that such changes, which were due to the nervous condition, and not to violence, should be fully understood, for it was suspected that undue violence had been exercised in the control of the patient, till it was found the patches appeared on areas where violence could not have been applied.

From July 25 his condition became worse. He occasionally had to be fed with the stomach pump, but as a rule took his food himself. His temperature rose, being generally three or four degrees above normal both morning and evening, and on the evening of August 1 it reached 103·8. During this period he had only slight head-ache, and no vomiting or convulsions. He could move all his limbs perfectly, and used to wander about his room at night. There was no facial, ocular, or lingual paralysis. The knee-jerks were absent. He was noisy, incoherent, and dirty. He generally kept his eyes closed, and when touched made himself rigid, but there did not appear to be any rigidity at other times. His tongue became dry and brown, and his pulse rapid and feeble. On August 4 he recognised and spoke to his wife, and on this day a red blush, about six inches square, fading on pressure, but without very defined margin, appeared on the outer side of his left thigh. The centre of this patch was tender, and there were a few hæmorrhagic spots in it. On the 5th of August, about noon, he became unconscious, and his breathing stertorous. In two hours his respiration ceased, but the pulse continued to be regular and stronger than it had been. Artificial respiration was kept up for three hours, when the pulse gradually failed and finally ceased.

Post-mortem there was found to be firm adhesion between the dura mater and calvarium, and on its inner surface, all over the convexity of the brain, but much more marked on the left side, was a thin gelatinous membrane of new formation, in the substance of which was much recent dark clot. Over the left frontal and parietal regions the clot was arranged principally in two lines, stretching backwards, and over the left temporosphenoidal and parietal lobes was of considerable thickness, and in some places grumous, and of a dirty reddish-brown colour. Over the right parietal lobe there was a whitish, streaky appearance as if of recent lymph on the surface of the clot.

The gelatinous layer and contained clot came away with the calvarium and dura mater, and there appeared to be no affection of the pia mater. The bones and vessels were apparently healthy, and there was no affection of the membranes at the base. On the upper surface of the left frontal and parietal lobes were a few roundish, discoloured spots, probably due to post-mortem staining.

The brain substance was soft and the vessels full, but otherwise there was no abnormality. The bladder showed no growth, no tubercle or cystitis, and contained no blood.

The left kidney was misplaced, being situated in the left side of the pelvis, behind the bladder. Both kidneys appeared to be normal in structure. The other viscera were healthy.

Hæmorrhagic pachymeningitis is of extreme rarity in acute cases of insanity, although met with in general paralysis and in chronic demented patients; its occurrence as extensively as it was found to exist in this case, where the patient was acutely maniacal, is therefore of great interest.

The question arises whether the maniacal symptoms were due primarily to pachymeningitis hæmorrhagica, or whether this was secondary to the acute mania. The greater part of the clot had certainly existed only a very short time, probably under a week, but the gelatinous membrane in which it was contained might have been of longer duration.

The question of purpura was discussed during life, but except for the blood passed per urethram there was no hæmorrhage from any mucous surface, and there were none of the abundant dark spots or subcutaneous hæmorrhages so often seen in purpura hæmorrhagica.

The blood passed was examined microscopically, and crystals of triple phosphate were discovered, but they were never present in the urine at any other time. Possibly the blood may have come from the left kidney, which might easily have been damaged by a blow before admission. It could be felt during life deep in the left iliac region, and was thought to be a fæcal mass. The wife said that he had fre-

quently complained during life of pain in the same region. There was, however, no evidence of injury in the shape of bruising of the abdomen, and post-mortem nothing could be detected to account for the hæmorrhage. We have only met with one other case in which a patient, soon after admission, passed pure blood, and in that case a rent was found in the bladder. In cases of purpura death sometimes occurs from cerebral hæmorrhage, and it would be interesting to know whether hæmorrhagic pachymeningitis may occur under the same conditions.

It is interesting to note that the patient had been a great sufferer from hay-asthma, and this year had been worse than ever before. From the onset of the attack of insanity all the signs of hay-asthma, however, disappeared.

Clinical Notes on Hæmorrhages in General Paralysis. By
GEO. H. SAVAGE, F.R.C.P.

In so-called nervous disorders it is common to find changes occur in other of the bodily systems than the nervous. The pathology of nervous disease should be looked upon as a general pathology, and it is certain that we cannot look to the one system alone for causes of all the nervous disorders without greatly misunderstanding the whole subject. The more exact we become in limiting the causes, the more liable are we to error. We are all prepared to consider general paralysis of the insane as essentially a disease of the nervous system, a disease in which nearly every part of the nervous system may suffer sooner or later. But beside the essentially nervous symptoms which occur in the disease, we are constantly struck by the regular series of nutritional changes which occur in general paralysis, and this is so much the case that we are quite prepared to recognise as general paralysis a disorder in which any mental symptoms have been present, but have after a brief period of acuteness been followed by a state of fatness and weak-mindedness which again has been followed by a period of wasting and further mental weakness. We have here nervous symptoms related very directly with nutritional changes.

Besides the changes which are found after death in the bodies of general paralytics, in the brain and cord, none are more common than those seen in the vascular system.

Thickening of the aorta and other vessels is common, and in life we see many cases with a tendency to capillary congestion and stasis, so that the patients have the aspect of persons suffering from cirrhosis of the liver. There is also commonly seen a greasiness of the skin as well as special pallor or anæmia.

Notwithstanding these changes, which are easily recognised, it has been found impossible to identify any peculiar condition of the blood itself in these cases. The sympathetic nervous system has hitherto fallen in for the chief blame for these nutritional changes, and some authors are inclined to credit this system with the chief part in the causation of general paralysis of the insane; but I think this is certainly not proved as yet, and the poor sympathetic has at present more than its share to bear, as every unknown pathological trouble is placed on the sympathetic, as it has, or is supposed to have, such influence in producing or preventing function that it is hard to say what it may not do or undo. My own experience leads me to say that I have not found anything on which I could lay my hands, either in the blood itself or in the sympathetic system in general paralysis. But now more in detail to my facts.

We all recognise as common, though not special to general paralysis, hæmatoma auris, and this is certainly due not alone to blows, but to slight injuries in a predisposed person, the fault being sometimes with the vessels, but perhaps sometimes with the blood. Besides these blood swellings we have also very large collections of blood which may form in general paralytics as a result of but slight injuries. These may occur on the head or extremities. Thus a patient may slip as he gets into or out of bed, and by the pressure of his own weight may produce an enormous swelling which in the course of a few days will be tense, and very much discoloured; such a swelling may also arise from a slight accidental blow on the face, and may produce black eyes of the worst appearance, at which both the friends and even juries may look with doubt as to the kindness of the treatment.

Such swellings may not only give rise to troublesome bruises, but as a secondary result blood-poisoning may occur. The chief characteristics of these blood-swellings is that a slight cause produces them, the swelling is rapid, and with little or no pain; there is little inflammation, but there may result one or more abscesses, containing either

pus or broken-down blood, and these abscesses heal rapidly and do not refill.

I have not been able to say whether blood or vessels were most to blame in these cases, but there is no doubt about the fluidity or diffusibility of the blood pigment as seen by the very extensive and rapid discolorisation following shortly on the formation of the swelling.

The next form of hæmorrhage I have to speak of is one which till recently was unknown to me, but I have now seen two or three well-marked cases in which blood has appeared in the urine without any traumatic cause.

In the two most marked cases the patients passed through the ordinary stages of general paralysis, and were in the third and last stage, being paralysed, wet and dirty. Some swelling of the prepuce occurred, and this was soon followed by a flow of bright arterial blood, which in the second case was found to be associated with crystals of triple phosphates. The blood passed was about three ounces at first, and later a constant oozing took place. There was no stricture, nor was there any sign of other renal or vesical trouble.

The hæmorrhage was just enough in both cases to turn the scale, so that patients who for months had held their ground and did not show any sign of sudden collapse, after the bleeding rapidly sank and died.

In the second case the bladder, the ureters, and kidneys were taken, and were handed over to Mr. Fenwick, of the London Hospital, who has prepared a full report of their condition, which will appear in the Transactions of the Pathological Society for 1886. The chief points of interest were that the bladder was found to be immensely thickened, the mucous membrane was traversed at pretty regular intervals by long vascular fringes, and the blood seemed to have come from one or more of these having given way, and was not due to any hæmorrhagic cystitis, such as was suggested as a cause by several surgeons who were consulted as to the probable cause.

On dissection Mr. Fenwick found that the entire vesicoprostate venous plexus was filled with a clot, non-adherent, but colourless, and, according to his opinion, this caused the fulness of the mucous fringes, and also the preputial swelling.

The thickening of the bladder walls, without any stricture, suggests a compensating hypertrophy, due to the bladder having to act under disadvantages, while the patient was

bedridden, and while the abdominal muscles were weakened; but this is only a suggestion of my own.

The last form of hæmorrhage has a double interest in being a skin affection, as well as evidence of a general state. A male patient, suffering from very acute general paralysis of the insane, managed to fall and bruise his left arm, and as a result a large blood-swelling followed, and this went on in the usual way for some days, when it was noticed that there was a purpuric rash on the inner side of both thighs, and also along the outer side of both thighs. The rash consisted of many hundreds of purpuric spots running in a narrow band along the thighs on the outer surface, from the ilium to the knees, and on the inner sides of the thighs from the fold of the groin, almost to the ankle.

This rash varied from day to day for nearly a week, then disappeared altogether. This is interesting from its relation to the other hæmorrhages in general paralysis of the insane.

Several cases of pigmentary stainings have appeared in Bethlem during the past year, and one reported in this number of the *Journal* by Dr. Percy Smith and myself, exhibited bruise-like markings all over the body in the course of a very acute nervous disease which ended fatally, and in this case also there was a tendency to hæmorrhage from the bladder.

I do not for a moment suppose these observations are unique, but I think they may be found worthy of consideration in relation to the larger pathology of nervous disorders, and so I publish them.

Counter Irritation in General Paralysis. By Dr. PRITCHARD DAVIES, County Asylum, Barming Heath, Kent.

On the 11th April, 1877, F. J. B. was admitted a patient into this asylum. The medical certificate which accompanied the order for his reception was as follows:—"Very excited when addressed. Has delusions on every point. Says that — has tried to murder him and seduce his wife. Complains that the two attendants have tried to murder and rob him. Imagines that he is to receive £50,000 per month salary as traveller. Thinks he is in treaty to purchase all the public-houses in England. His brother — informs me that he has threatened to murder his wife with a revolver—

is extremely violent and dangerous to others. Has delusions on money matters, is extremely suspicious, and thinks people are going to murder him."

This attack was said to be his first, and probably of three days' duration. His age was given as 36 years; there was no hereditary history of insanity or other neurosis, but it appeared he had led a very "fast life," being unduly fond of both wine and women. The immediate cause of his malady was said to be a debauch he had indulged in when by betting on horse-racing, he had won a large sum of money. It is recorded in the Case-book that, upon admission, "he was in a very excited and restless condition, nervous and agitated, his mind rapidly wandering from one subject to another. Very incoherent in conversation, with extreme delusions mostly of an exalted nature, one being that he is going to buy this asylum and make a distillery of it. Physically he is of average height, well developed, and fairly nourished. Very tremulous about lips and tongue, has also a hesitancy in his speech."

This case was diagnosed as one of general paralysis of the insane, and for a time it progressed in the ordinary way. He is recorded as having continued violent, incoherent, and destructive up to the end of the following May. There was certainly no sign of improvement, but rather a steady deterioration all this time. About this period he developed a carbuncle on the back, and this pulled him down rapidly, so much so indeed that at one time death appeared imminent, and his friends were sent for. On June 13th he had what the attendant in charge of his ward called "an epileptic fit," and when visited shortly afterwards by the assistant medical officer, he was found to be in the following condition, viz.: "Flexors of the forearms rigidly contracted, the right hand being raised to the head and resisting removal, the head bent on chest, face flushed, teeth clenched, and a little foam at the mouth; pupils rather dilated, but responded to light, and conjunctivæ sensible to touch." Fourteen hours later he was still unconscious, and the note made after a further period of 24 hours was that he was only "less unconscious," nor was it until about 48 hours from his seizure on the 13th inst. that he was "able to swallow fluids and open his eyes." For two weeks longer he was in great danger, and in addition to the carbuncle he now had a large bed-sore over the sacrum.

On December 6th it is recorded that "his strength has

greatly increased. Thinks that the asylum is his own property." From this date up to the present time he has remained quiet, full of delusions, but all of a perfectly harmless nature. There has been no return of excitement, and he makes himself generally useful. The tremor of lips and tongue is no longer perceptible, nor can any hesitancy of speech be observed. His general health all this time has been, and is now, very good.

I dwell upon this case somewhat in detail, as it furnished me with an idea for a new departure in my treatment of general paralysis. That this was a case of that disease, only the fact that the patient is alive now causes me the least hesitancy of belief. When brought here he was in such a state that few if any competent observers would have felt at all dubious as to the nature of his malady. His restoration to general health, and the complete arrest of his mental symptoms, surprised me not a little. The only thing that I observed in his case different from that of the many that had come under my care, was the advent of a carbuncle, which ran a very severe course. Could it be possible, I thought, that this carbuncle, acting as a counter-irritant, had influenced the course of the disease. There was only one way of testing the accuracy of this supposition, viz., by taking a similar case and trying to artificially produce an analogous condition. Unfortunately we but seldom receive patients in the early stage of general paralysis. They are more commonly far advanced when brought here, and practically beyond human aid. Then, again, I had difficulty in choosing a suitable counter-irritant. I tried many—I may almost say, everything likely to produce sustained irritation. In the end I found iodine better than anything else, have used it exclusively, and I think with decided benefit. While I am unable to say that I have by its means actually cured any case, or even arrested the progress of one as completely as appears to have been done in that of F. J. B., I am satisfied that I have prolonged life, and am disposed to believe that if adopted at the outset of the malady—*i.e.*, before the patients are certified as insane—the result would be most encouraging.

It is my practice to apply the liniment of iodine over the whole length of the spine, and also over each side of the neck. This is not done all at once, however, for the object being to keep up a prolonged action, I paint one side of the neck and a portion of the spine until signs of vesication are distinctly

visible, then the other side of the neck and the remainder of the spinal region. While these second painted parts are getting tender, the first treated are healing. In this way I have found it possible to keep up well-marked counter-irritation for weeks or even months together. To be of any benefit indeed I do not think it advisable to discontinue the treatment under a month, and have frequently used it for much longer periods with marked ultimate advantage.

I think it possible that the iodine acts in two ways, viz., firstly, as a simple counter-irritant, and secondly, by combining with the exuded lymph, it forms a soluble compound which is removed by absorption.

I know of only one objection to this mode of treatment, and that is the conviction attendants and patients have that "blistering" in any form is but a punishment. The friends of patients often share this idea, and not unfrequently give unpleasant evidence of their erroneous belief. Doubtless the ignorance of all that is now being done or tried to be done in asylums, which is so universal, is at the root of this.

Still I hope others will not be deterred by this consideration, but give what I advocate a fair trial.

OCCASIONAL NOTES OF THE QUARTER.

The Late Earl of Shaftesbury.

It is a remarkable circumstance that the obituary notices of the Earl of Shaftesbury which have appeared in the daily papers make very slight reference to his lordship's great services to the insane. Nothing more forcibly indicates the wide extent of his philanthropic work than that, after enumerating various movements in which the Earl took a prominent part, little room—only some half-dozen lines—should be left for what still remains one of the most important of the interests which occupied his active life, and that which obviously calls from us more especial attention and notice, a tribute, indeed, of sincerest respect and gratitude.

The "Times," in a single sentence, enumerates as organizations indebted to him for active aid, sympathy, and advice, "the British and Foreign Bible Society, the Religious Tract Society, the London City Mission, the Sunday School Union,

the Field Lane Refuges and Ragged Schools, the National Refuges for Homeless and Destitute Children," and adds fifteen societies of which he was president, and seventeen of which he was vice-president. How he found time to pay any considerable attention to so many objects is remarkable, when we consider that he devoted so large an amount of personal attention to them, which was not actually required of him. We take, as the best illustration at hand, his action in a society of which he was president without expressing any opinion as to its beneficial character. Miss Cobbe has stated that she had received no less than 260 letters from Lord Shaftesbury in regard to the operations of the Society for the Total Abolition of Vivisection. *Ex uno disce omnes.* What we aim at is to show that the late Earl devoted his energies to all kinds of benevolence, whether in the interests of man or the lower animals, and that in spite of these innumerable calls upon his time, he attended to his duties as Chairman of the Lunacy Board in a most painstaking and conscientious manner. To the assiduity and punctuality with which these duties were performed, none will bear more willing testimony than his colleagues in Whitehall Place, and we have reason to know that his return to his post after resigning it in consequence of what he deemed objectionable provisions in the late abortive Lunacy Bill, was in great measure due to the remonstrances of his brother Commissioners.

It was the good fortune of Lord Shaftesbury not only to take the lead in legislative measures for the amelioration of the condition of the insane, but as Chairman of the Lunacy Board for more than half a century to witness their success. The organization of this Board formed a part of the movement which, already in progress prior to the time of Lord Ashley, received from him so remarkable an impulse. It has been pointed out in the newspapers that Lord Shaftesbury, in taking an active part in the beneficent legislation for factory operatives, gave credit to Mr. Sadler and others for originating the movement, of which he became the parliamentary champion. Similarly, he paid a generous tribute to the labours of his predecessors in the reform of the treatment of the insane, as may be seen by a reference to his speech in 1845, when he introduced his well-known Bills into the House of Commons (8 and 9 Vic., c. 100 and c. 126). In this speech Lord Ashley referred to the introduction of a humane system of treatment into England by the example

set by the York Retreat, and identified with that reform the action he besought Parliament to take in enforcing the humane care of the insane by stringent legislation.

We must go back, however, some years to note that, as early as 1828, Lord Ashley seconded Mr. Gordon's Bill to amend the law regulating Lunatic Asylums.

The remarkable Report of the Metropolitan Commissioners who, in consequence of the Act of 1828, were appointed in place of five Commissioners from the College of Physicians, appeared in 1844; in fact it was upon this report that Lord Ashley moved for an Address to the Crown praying her Majesty to take it into consideration which led to the introduction of the Bill of 1845, to which we have referred. It was this Bill which established a Lunacy Commission for England and Wales. Lord Ashley was Chairman of the Board from its commencement, and had previously been Chairman of the Metropolitan Commissioners from the year 1834, and had been a member from its appointment in 1828.

In the subsequent amendments of Lord Ashley's Act, he himself took a leading part, and from that date to the time of his death he never absented himself from the debates on any Lunacy Bill brought before Parliament, with the solitary exception of Lord Selborne's in 1885, when he did so in consequence of his strong disapproval of the clauses in the Bill which required the interposition of the magistrate prior to the removal of private patients to asylums.

Lord Shaftesbury was foremost in his advocacy of a distinct asylum for criminal lunatics, and introduced the subject of the special provision for this class in a State Asylum into the House of Lords in the year 1852. After extolling the improved system introduced by Pinel on the Continent, and by the Retreat in our own country, he exclaimed "*Oh, si sic omnia!*" and added, "the filthy and formidable prison (asylum) is converted into the cleanly and cheerful abode; the damp and gloomy courtyard is exchanged for healthy exercise and labour in the field and garden. Visit the largest asylum, and you will no longer hear those frightful yells that at first terrify and always depress the boldest hearts. Mechanical restraint is almost unknown; houses where many were chained during the day, and hundreds, I will assert, during the night, have hardly a strait waistcoat or a manacle in the whole establishment; and instead of the keeper with his whip and his bunch of leg-locks, you may see the clergyman or the schoolmaster engaged in their soothing and

effective occupations." It was not, however, until 1860 that an Act for the better provision for the custody and care of criminal lunatics was passed, and, in consequence, the State Criminal Asylum at Broadmoor, for which England is envied by some Continental countries, was erected in 1863.

In a more recent movement, Lord Shaftesbury took great interest—the "After Care Society," established in 1879, the object of which is to assist female patients discharged recovered from county asylums in obtaining situations, especially in domestic service. He willingly became its first patron, and subsequently its president. At the last meeting of the society the Secretary, the Rev. H. Hawkins, made the following statement concerning Earl Shaftesbury's connection with this movement:—

"When late in 1879 a printed paper (by Rev. H. Hawkins, Chaplain of Colney Hatch Asylum) was brought under Lord Shaftesbury's notice, he wrote in reply:—'Your letter, entitled "After Care," has deeply interested me. The subject has long been on my mind, but, like many other subjects, it has passed without any effectual movement on its behalf.'

"Subsequently, in answer to an invitation from the association, a reply was received:—'I am directed by the Earl of Shaftesbury to say that he shall be happy to accept the office of Patron to the Association for After Care.'

"Lord Shaftesbury presided, and took active part in the business at the anniversaries 1881, 1882, 1883, 1884, at the houses respectively of Sir Andrew Clark, Dr. Ogle, Lord Cottesloe, and Lord Brabazon.

"Indisposition prevented him from opening, as he had engaged to do, the bazaar held in May last, in Kensington, and from attending the anniversary at Bethlem Hospital on 2nd July.

"At Lord Brabazon's, Lord Shaftesbury expressed his opinion that the 'After Care' Association was needed to supply a real want, and he stated his belief that it was a seed-plot from which, in due time, good results would spring.

"With regard to the subject of a distinct Home, Lord Shaftesbury, through his secretary, in a letter to the Rev. H. Hawkins, expressed himself as being 'decidedly in favour of a "Home" for friendless female convalescents on leaving lunatic asylums,' and, at the meeting at Lord Brabazon's, he said he considered such a home a necessity, and did not see how such a resort could be dispensed with."

We are aware that the observations we have made fail to convey a full and correct idea of the life-long devotion of the good Earl Shaftesbury to a cause in which so few took, as he did, not only a warm, but a judicious part in the direction of reform. On several occasions his proposals were coolly received in the House of Lords, and were indefinitely postponed, as in the instance of his proposal to establish a State Criminal Asylum, which was opposed by the late Earl of Derby as totally unnecessary. The shortcomings of the present article are, however, to some extent, supplied by the remarks we made in a former number of the Journal on the occasion of Earl Shaftesbury's resignation of the Chairmanship of the Lunacy Board. We can only hope that the successor of the late Chairman will be animated by the same spirit, although it cannot be expected that he will occupy the same position for so long a term of service.

In the recently published volumes of Mr. Greville's "Memoirs" mention is made of Lord Ashley in the following terms:—"A philanthropic agitator is more dangerous than a repealer, either of the Union or the Corn Laws. We are just now overrun with philanthropy, and God knows where it will stop or whither it will lead us." And again, "Ashley has put himself at the head of the Low Church Party, and will make a great clatter." To what the "philanthropy" so much dreaded by Mr. Greville and the "great clatter" did "lead" we now know, and the cynicism of the passage we have quoted forms a strange contrast to the feeling which found expression in the funeral ceremony in Westminster Abbey when all parties paid their last tribute of reverent respect to the "Philanthropic Agitator."

Inauguration of the Statue of Pinel in Paris.

We are glad to be able to record that the inauguration of the statue of the illustrious Pinel successfully took place at the Salpêtrière on the 13th of July, 1885, a century, within eight years, after the commencement of the great work which he accomplished at that institution and at the Bicêtre; indeed the associations of the majority of persons familiar with the courageous reform introduced by Pinel is rather with the latter hospital than with the former.

The erection of this statue is due to the action of the *Société Medico-psychologique* of Paris, which some years ago decided upon this course, and invited the co-operation not

only of Frenchmen, but of the admirers of Pinel in other countries. The artist, M. Ludovic Durand, has added to the effect of the bronze statue of one who was at once philanthropic and possessed of the knowledge of man, by placing on either side of Pinel the figures of Charity and Science. An insane female who sits at his feet, is supposed to be offering him flowers after he has removed her chains, which he holds in his right hand.

Present at the inauguration were the Prefect of the Seine and of Police, the President of the Municipal and General Council, the Delegates of the Minister of the Interior, of Public Instruction, of the Fine Arts, of the Institute, and of the Academy of Medicine, and the Director of the General Administration of Public Assistance. Public homage was therefore rendered, as the report of the proceedings expresses it, to a great citizen whose character, whose dignified life, and whose services to humanity and to his country received, amidst universal applause, a recompense as great as it was well deserved. The President of the Society was present and spoke in its name, and congratulated the descendants of Pinel, Honorè and Charles Pinel, and their families, while he pointed to the statue "*d'un grand et illustre citoyen*" as a pious homage destined to perpetuate the memory of "*un homme de bien*," and lastly presented the statue of Pinel in the name of the Medico-Psychological Society to the city of Paris.

Dr. Robinet, Vice-President of the Municipal Council, to which belongs in part the administration of lunatic asylums, contrasted the former condition of the Salpêtrière and the Bicêtre with their present state along with other asylums of the department, and by this means brought into strong relief the debt of gratitude due to "the great reformer of an odious system." Part of a description quoted from Pariset in his *éloge* of Pinel deserves quotation: "At the Bicêtre and at the Salpêtrière, vice, crime, misery, and the most disgusting and the most dissimilar diseases were confounded together in the wards. The buildings were uninhabitable. Men were crowded together covered with vermin in cells built altogether of stone, small, cold, and, damp, deprived of air and light, the only furniture being straw beds, which were rarely changed, and soon became infected—frightful dens in which one would hesitate to place the vilest animals. The insane who were thrown into these *cloaques* were at the mercy of their keepers, and these latter were malefactors from

the prison. The unfortunate patients were loaded with chains and bound like convicts; thus subjected to the brutality of their keepers, they were the objects of the most cruel treatment, which day and night drew from them cries and yells, thus rendering still more frightful the clanking of their chains. Women were chained sometimes naked in the almost subterranean cells and worse than dungeons. At the time of the rise of the Seine, these were invaded by rats, which during the night attacked them, and gnawed them wherever they could reach them. At the morning visit some patients were found with their feet devoured by these animals, and they often succumbed. Thus attacked on all sides, their wounded heart only breathed vengeance, and in the intoxication of hatred which filled them, they only sought like bacchanals to destroy their nurses or to injure one another." For this condition of restraint and torture Pinel substituted treatment in which justice was tempered with benevolence. No more irons, no more chains; quiet patients were allowed every liberty possible. We here quote the words of Dr. Robinet, who ended his discourse with "*Au nom de Paris, hommage et salut à la grande figure de Pinel!*"

The Prefect of the Seine, in thanking the Society for their initiation of the movement, officially accepted the offer of the statue of Pinel to the city of Paris. The Prefect appropriately recalled the memory of a character well known to the readers of Pinel's writings, Pussin, "the modest servant who carried out so faithfully his master's behests."

Dr. Legrand du Saulle, to whom the Committee had from the commencement delegated its functions (lasting over a period of seven years), paid a glowing tribute not only to Pinel, but also to the President of the Committee, Dr. Baillarger, who had passed 32 years of his life at the Salpêtrière, and whom he justly characterised as one of Pinel's most ardent successors. Unfortunately the state of his health prevented his being present on the occasion. The speaker, in the sketch he gave of the movement which led to this inauguration, quoted the following words from a Commission nominated by the Society in December, 1877, which made report March 25, 1878: "France distracted by so many events, and scarcely regarding the tender memories of the distant past, has allowed its debt to Pinel to grow. A century will shortly separate us from the great reform

effected by the philanthropic *savant* of Bicêtre without the *éclat* of his beneficent work having come to an end." At a meeting of the Society, the proposition to recognise publicly the great claims of Pinel was unanimously agreed to in the following terms: "The Medico-Psychological Society considering that Philippe Pinel is one of the purest medical glories of France, seeing that it is at his bold and clear initiative that in 1792 the chains fell from the insane at Bicêtre, seeing that he is the true founder of the Science of Mental Maladies, seeing that he has founded at the Salpêtrière, by his brilliant and productive intelligence, a very great school of students, who have spread his ideas, reforms, and beneficence everywhere, it is resolved that a statue be erected to Philippe Pinel in Paris."

This resolution having become a reality, Dr. Legrand du Saulle returned thanks in eloquent terms to the various public functionaries, the subscribers, and to the artist, M. Durand "*avec une profonde émotion.*"

Dr. Ritti, the general Secretary of the Society, delivered at its request a eulogium on Pinel. His eloquent oration merits perusal throughout. We regret to have only space for the peroration. "The memory of Pinel remains vivid and pure as that of '*un homme de bien.*' If he deserves gratitude from all for the social reform with which his name will always be associated, he has especial claims on the medical profession. Is it not he who has opened up the way for us? Is he not our first master in mental alienation? Like Virgil in Dante he has acted as our guide in these dark abodes of suffering and tears; he has excited our compassion by inducing us to witness the sufferings and agonies of the unhappy patients chained like malefactors; but happier than the poet it has been permitted him to assuage these great misfortunes; he has liberated the insane from their fetters and brought tranquillity and hope to these sorrowful hearts, where only despair and fear reigned. He has done more, he has proved that insanity, supposed to be incurable, can be overcome by rational and humane treatment; thus, having accomplished this beneficent task, Pinel was able to efface from the entrance to these gloomy abodes the sinister inscription: All hope abandon, ye who enter here. This work is great and beautiful. The illustrious man who has accomplished it has deserved well of Science and Humanity."

This remarkable ceremony ended with a short but effec-

tive speech from M. Pichon, a member of the Municipal Council.

Dr. Motet has drawn up a concise but interesting report of the proceedings which took place at the inauguration of the statue, to which we have to acknowledge our indebtedness. It only remains for us to congratulate our French *confrères* on the successful completion of an undertaking which has involved a large amount of labour and thought. Although in our own country the reform of the condition of the insane, originated without any knowledge of the humane and bloodless revolution which in the very midst of one of an opposite character was effected, the name of Pinel is venerated by all of us who are interested in the past and present condition of this then neglected class of humanity, whose lot the humane Frenchman and his English contemporary at the York Retreat, having found intolerable, so vastly bettered.

PART II.—REVIEWS.

Thirty-Ninth Report of the Commissioners in Lunacy. July, 1885.

In this 39th report of the Commissioners in Lunacy for the year 1884, we are again presented with a comprehensive statement of important facts, which have an interest alike for our own profession and specialty, and for a wider public, every one of whom is more or less affected by them.

On the 1st January, 1884, the number of persons of unsound mind included in the usual returns to the lunacy office was 78,528. On the 1st January, 1885, it had increased by 1,176, or to 79,704, showing the same proportion to population of one in every 345 as last year, and distributed as shown in table on opposite page.

The Criminal Lunatics Act of 1884 having come into operation since the last report was issued, it will be seen that this table contains a new column giving the number of criminal patients as distinct from the private and pauper classes.

The numbers thus tabulated, as compared with those of last year, show a decrease of 74 private patients, an increase of 1,256 pauper patients, and a decrease of six criminals.

WHERE MAINTAINED on 1st January, 1885.	PRIVATE.			PAUPER.			CRIMINAL.			TOTAL.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
In County and Borough Asylums	334	391	725	21,066	25,781	46,847	139	38	177	21,539	26,210	47,749
In Registered Hospitals.....	1,530	1,436	2,966	99	51	150	2	—	2	1,631	1,487	3,118
In Licensed Houses :												
Metropolitan	934	850	1,784	173	384	537	3	—	3	1,110	1,214	2,324
Provincial	693	849	1,542	201	302	503	6	1	7	900	1,152	2,052
In Naval and Military Hospitals, and Royal India Asylum	270	19	289	—	—	—	—	—	—	270	19	289
In Criminal Lunatic Asylum (Broadmoor)	—	—	—	—	—	—	400	143	549	408	143	549
In Workhouses :												
Ordinary Workhouses...	—	—	—	5,050	6,828	11,878	—	—	—	5,050	6,828	11,878
Metropolitan District Asylums	—	—	—	2,489	2,915	5,404	—	—	—	2,489	2,915	5,404
Private Single Patients	189	256	445	—	—	—	—	—	—	189	256	445
Out-door Paupers	—	—	—	2,255	3,641	5,896	—	—	—	2,255	3,641	5,896
TOTAL.....	3,950	3,801	7,751	31,333	39,882	71,215	556	182	738	35,839	43,865	79,704

The total increase of the year is considerably below the annual average increase of past years.

In relation to this table and to Table III., which gives the ratio of admissions into institutions and single care to the estimated population, the remarks and conclusions of the Commissioners are especially interesting and important. They say:—"In last year's report it was stated that the proportion had not risen perceptibly from 1875 to 1882, at which latter date the annual proportion of fresh cases was 5.15 per 10,000 of the population, but for 1883 there was an advance to 5.41 per 10,000. This advance was, however, found to be due to local and exceptional conditions, particularly the admission into the Lancashire Asylums of an unusually large number of imbeciles, long resident in workhouses, and therefore not fresh cases of insanity. The excess in the admissions due to this cause having been calculated and eliminated, it was found that the ratio of fresh cases in 1883 came down to 5.15 per 10,000, or about the proportion which had prevailed since 1875. The ratio of admissions for 1884, as shown by this table, is 5.27 per 10,000, but it is to be observed that the same wholesale deportation of imbeciles from the Lancashire workhouses to the asylums has continued in operation during the year. The total admissions into all the Lancashire asylums (excluding transfers from other asylums) was 2,053 in 1884, which is 861 above the average annual admissions of the four years 1879-1882, a period antecedent to this process of emptying the workhouses of chronic cases. Now if this excess of 861 be deducted from the 14,312 total admissions of the year, the ratio of fresh admissions to population for 1884 is brought down to 4.95 per 10,000, which is somewhat lower than has prevailed during the last 10 years. These figures tend to support the conclusion stated in our last report, in which the following paragraph occurs: 'The large annual addition to the number of insane persons under care, has produced in some quarters an impression that insanity itself is much on the increase. On examination, however, of the figures now under consideration, it will be found that the increase is almost entirely due to accumulation of chronic cases of the pauper class, so that the community at large would not appear more liable than formerly to be attacked with insanity.' At the same time, as there is as yet no indication of any material decrease in this accumulation of chronic cases, the local authorities cannot be relieved from the responsibility of making due prospective

provision for the annually increasing number of the insane poor requiring maintenance, care, and treatment."

The ratios of paupers to population, and of pauper lunatics to paupers, have been practically identical with those of last year.

Of the 14,512 patients admitted during the year under review into the various classes of asylums and into single care, 11,939 were received into County and Borough Asylums; 654 into Registered Hospitals; 923 into Metropolitan and 458 into Provincial Licensed Houses; 190 into Naval and Military Hospitals and the India Asylum; 55 into the Criminal Asylum at Broadmoor; 200 into Idiot Asylums; and 93 into private care.

Of these patients (after excluding the idiots and transfers), the County and Borough Asylums discharged as recovered 4,749, or 39·77 per cent.; Hospitals, 378, or 57·79 per cent.; Metropolitan Licensed Houses, 287, or 31·09 per cent.; Provincial Licensed Houses, 219, or 47·81 per cent.; Naval and Military Hospitals and the India Asylum, 123, or 64·73 per cent.; Broadmoor, 2, or 3·63 per cent.; and private care, 15, or 16·12 per cent.

The average percentage of recoveries in all these centres of treatment was 40·33, as against 39·51, the average of the last 10 years.

Of 5,332 patients who died during the year, 4,733, or 10·03 per cent., were in County and Borough Asylums; 122, or 5·98 per cent. in Hospitals; 227, or 10·47 per cent., in Metropolitan Licensed Houses; 143, or 7·57 per cent., in Provincial Licensed Houses; 18, or 6·18 per cent., in Naval and Military Hospitals; 19, or 3·46 per cent., at Broadmoor; 44, or 2·96 per cent., in Idiot Asylums; and 26, or 5·88 per cent., in private care; the general average of deaths to the daily numbers resident under these various circumstances being 9·51 per cent., as compared with 9·77, the average of the last 10 years.

The ratios of recoveries and deaths are, therefore, to be regarded as not unsatisfactory.

The proportion of patients maintained in workhouses and with relatives or others, still shows signs of steady decrease, as against an increase in County and Borough Asylums. In Lancashire this has been especially the case, for there the ratio in the latter has increased from 67·2 per cent. on Jan. 1, 1884, to 72·1 on Jan. 1, 1885, the proportion of patients kept in workhouses having fallen from 30·6 to 25·8 per cent. This process, which commenced last year, was made the

subject of unfavourable comment by the Commissioners, and they again refer to it and to the general question of the maintenance of patients in workhouses in the following remarks:—"In our report for 1884 we pointed out that the decrease in this class of pauper lunatics, which we then reported, was mainly due to the removal of a large number of patients from Lancashire Workhouses to the County Asylums. This transfer continued during the past year, and there were in these workhouses 340 fewer lunatics on 1st January, 1885, than on 1st January, 1884. It was, however, confined chiefly to the six workhouses of six unions, namely, those of Bolton, Bury, Chorlton, Manchester, Salford, and West Derby, which, collectively, had, on the 1st January, 1885, 353 fewer lunatics than on the corresponding day of the previous year.

"From the Bury Workhouse a considerable number of lunatics, who had shortly before been certified by the medical officer to be 'proper patients to be kept in the workhouse,' were removed to the Prestwich Asylum on certificates signed by the same medical officer, and we thought it right to request from him an explanation of his reasons for so acting. His reply was to the effect that he had acted on instructions received from the Clerk to the Guardians. It appeared to us that the matter was one which should be referred to the Local Government Board, between whom and the Guardians a correspondence ensued, in which the latter stated, 'that the chronic harmless lunatics were removed because the Guardians wished to make use of the present imbecile wards of the workhouse for infirmary accommodation,' adding that there were difficulties in the way of providing this accommodation in any other manner. Motives somewhat similar would appear to have actuated the Guardians of the other unions, from which large transfers of chronic and harmless lunatics have been made; but it seems to us a shortsighted policy, as well as a costly one, to occupy with chronic patients the space in the County Asylums which must soon be required for recent and curable cases.

"In our Thirty-seventh Report we described, at some length, this question of the removal from workhouses to asylums of chronic cases in its general aspect, and mentioned that we had brought it under the notice of the Local Government Board. At their suggestion we obtained from the Superintendents of the County and Borough Asylums nominal returns of patients who, in the judgment of the Superintendents, might be adequately taken care of in the

workhouses of their respective unions, assuming that if removed thither they would be placed on the 'Dietary of the Aged and Infirm,' or one equally good. The lists were divided into three classes: (1) cases suitable for care in special lunatic wards of workhouses; (2) those suitable for care in workhouse infirmaries with paid nurses; and (3) those suitable for ordinary workhouse wards. Of the first class, 4,095 cases were returned; of the second, 1,264; and of the third, 386. The numbers returned varied considerably in different asylums in their proportion to the entire insane population, and they appeared to us to be governed very much by the particular views entertained by the Superintendents on the subject of the treatment of chronic lunatics in workhouses. We thought, however, that the returns established the fact that an important proportion of the present asylum population might be adequately and more economically provided for in workhouses, and we expressed this opinion to the Local Government Board, who adopted it to the extent of preparing towards the close of the year a circular addressed to each Board of Guardians giving the names of patients belonging to their union, who were included in either the second or the third of the above classes, and requesting to be furnished with the observations of the Guardians thereon. We do not yet know what effect this step has produced or will produce."

The assigned causes of insanity in the private and pauper patients, and in the general paralytics of the year are shown in table (on p. 524) in percentages.

The percentages of patients in whom epilepsy and general paralysis were present in the admissions of the last seven years are shown in the following table:—

YEAR.	EPILEPTICS.						GENERAL PARALYTICS.					
	PRIVATE.			PAUPER.			PRIVATE.			PAUPER.		
1878	7.7	2.8	5.6	12.3	8.6	10.4	11.1	0.8	6.5	14.4	3.7	9.0
1879	7.9	3.5	5.9	12.1	8.0	10.0	8.8	1.0	5.2	13.6	3.6	8.4
1880	6.0	3.4	4.7	11.1	8.0	9.5	7.9	2.2	5.1	12.5	3.5	7.7
1881	5.4	3.6	4.5	11.9	8.3	10.1	9.4	2.0	5.9	12.4	3.5	7.7
1882	5.2	2.8	4.0	12.5	8.1	10.2	10.9	1.4	6.3	14.4	3.6	8.9
1883	4.9	2.8	3.9	12.4	8.6	10.4	10.2	1.7	6.2	13.7	3.5	8.3
1884	5.0	2.6	3.8	12.7	8.2	10.4	9.7	1.0	5.5	14.6	3.1	8.7

CAUSES OF INSANITY.	Proportion [per Cent.] to the Total Number of Patients in each Class Admitted.						Proportion [per Cent.] to the Total Number of General Paraly- tics Admitted.		
	PRIVATE.			PAUPER.					
	M.	F.	T.	M.	F.	T.	M.	F.	T.
MORAL :									
Domestic Trouble (including loss of relatives and friends)	4.0	10.1	6.9	4.5	9.3	7.0	3.1	8.7	4.1
Adverse Circumstances (including business anxieties and pecuniary difficulties)	8.7	2.5	5.7	7.1	3.5	5.3	10.3	5.8	9.5
Mental Anxiety and "Worry" (not included under the above two heads), and Overwork	17.4	10.9	14.3	4.4	4.4	4.4	6.8	5.3	6.5
Religious Excitement	2.3	5.2	3.7	3.0	3.1	3.0	.8	—	.7
Love Affairs (including Seduction) .....	.6	3.3	1.9	.4	2.1	1.3	.1	.5	.2
Fright and Nervous Shock	1.1	2.9	1.9	.7	1.8	1.3	.5	.5	.5
PHYSICAL :									
Intemperance, in Drink.....	17.6	5.6	11.8	19.5	7.4	13.4	23.3	15.5	21.9
" Sexual.....	1.6	.3	.9	.4	.6	.5	2.5	2.9	2.6
Venereal Disease	1.3	.5	.9	.5	.2	.4	1.6	1.9	1.7
Self-abuse (Sexual)	4.8	1.9	3.4	1.5	.1	.8	.5	—	.4
Over-exertion	1.1	.4	.7	.4	.3	.4	.6	.5	.6
Sunstroke.....	1.9	—	.9	2.0	.2	1.1	2.1	.5	1.8
Accident or Injury	2.9	.9	1.9	5.6	.6	3.1	8.0	1.0	6.8
Pregnancy	—	1.0	.4	—	.7	.3	—	1.0	.2
Parturition, and the Puerperal State	—	7.6	3.6	—	6.5	3.3	—	2.4	.4
Lactation	—	1.1	.5	—	2.4	1.2	—	.5	.1
Uterine and Ovarian Disorders ...	—	4.5	2.1	—	1.7	.8	—	2.4	.4
Puberty.....	.2	1.3	.7	.1	.8	.5	—	—	—
Change of Life	—	6.2	2.9	—	4.5	2.3	—	4.8	.8
Fevers	1.3	.9	1.1	.2	.4	.3	.2	—	.2
Privation and Starvation .....	.2	.1	.1	1.8	2.3	2.0	.9	5.3	1.7
Old Age.....	3.2	3.4	3.3	3.8	5.2	4.5	.1	.5	.2
Other Bodily Diseases or Disorders	8.6	6.5	7.6	11.3	11.7	11.5	10.1	16.0	11.1
Previous Attacks	14.0	20.5	17.1	14.7	19.9	17.4	5.5	5.8	5.5
Hereditary Influence ascertained	16.6	19.4	18.0	18.5	22.6	20.6	14.8	19.4	15.6
Congenital Defect ascertained ...	11.4	5.1	8.4	4.3	3.3	3.8	.2	.5	.2
Other ascertained causes	3.9	.8	2.4	1.4	.6	1.0	1.2	.5	1.1
Unknown	12.0	10.1	11.1	25.1	20.9	23.0	33.7	29.6	32.9

Of the 14,308 patients admitted into asylums, &c., during the year 1884, 44 per cent. were single, 44 per cent. married, and 12 per cent. widowed. Mania was the form of mental disorder assumed in 47 per cent. ; melancholia in 25 per cent. ; dementia in 17 per cent. ; and congenital insanity in about six per cent. The patients were the subjects of the first attack of insanity in 66·8 per cent. of the admissions, and the suicidal tendency was admitted in 28·2 per cent. The married general paralytics admitted during the year were in the proportion of 13·6 per cent. to 3·4 per cent. of single persons, which is interesting in relation to the fact that of those suffering from all forms of mental disorder, single and married were admitted in about equal proportions.

The interesting and elaborate series of new tables which give the occupations of the patients admitted during a term of years, in relation to the population of England and Wales, and to those occupations in the population, and the condition of the patients admitted as to marriage, &c., will become increasingly valuable as the periods which are comprised in them extend, and a closer approximation is made to the probable actual population at the time, rather than to that at the last census.

The Commissioners report 18 deaths by suicide during the year, but of these only 15 occurred while the patients were under care in establishments, into which, in the five years from 1879 to 1882, no less than 19,000 suicidal patients were admitted. Nine deaths occurred during the year from suffocation in epileptic fits.

The following tables and remarks are interesting, the former as showing at a glance the changes of the year among the asylum population.

“During the year 1884 there were 14,833 admissions, as shown below :—

	MALES.	FEMALES.	TOTAL.
Total Number	7,083	7,750	14,833
Deduct Transfers from other Asylums	1,206	1,683	2,894
Number of Persons placed under care during the year	5,877	6,062	11,939

The re-admissions, *i.e.*, of patients who had been in the same asylum before, were 1,676 in number.

The number of discharges during the year were :—

	MALES.	FEMALES.	TOTAL.
Discharged " recovered "	2,035	2,714	4,749
„ " not recovered " including trans- fers	1,536	1,916	3,452
Total	3,571	4,630	8,201

The deaths were 5,332 in number, of which 2,952 were in the cases of male, and 2,380 of female patients. In 3,261 instances post-mortem examinations were made, almost 69 per cent., the same ratio as for the year 1883.

Out of the whole number of patients resident on the 1st January, 1885, there were deemed to be curable 2,819 persons, a proportion of 5·9 per cent. of the whole; on the 1st January, 1884, this proportion was 6·3 per cent.; the difference is doubtless largely caused by the great number of chronic and incurable patients who were poured into the Lancashire Asylums, during the past two years, from certain union workhouses in that county.

The recovery and death rates are shown by the following calculations :—

	MALES.	FEMALES.	TOTAL.
Proportions per cent. :			
Recoveries to admissions (excluding trans- fers)	34·62	44·77	39·77
Deaths to daily average number resident	12·19	8·25	10·03
Deaths to total number under treatment...	9·35	6·49	7·79

The recovery rate, for both sexes taken together, is rather lower than the average of the 10 preceding years, though the females taken separately show a higher rate. The death-rates are also slightly lower than the same average.

The Commissioners give a *resumé* of the additions to, and alterations in, county asylums which have been effected during the past year, and enumerate the steps which have been taken to provide separate accommodation for the pauper lunatics of boroughs in which no such provision had previously existed. Derby, Exeter, and Plymouth have all taken action with this view, but York is still recalcitrant, "to the great detriment," as the Commissioners very properly put it,

“of what ought to be an important charitable institution,” the York Lunatic Hospital.

That this complaint is not unfounded may be safely inferred from the facts stated in the Reports of that Institution. At the end of 1874 the number of patients was 184, of whom 41 at least paid less than £1 a week. At the end of 1884, the total number of patients was only 152, while those classified under the same heads as in receipt of charitable assistance from the funds had fallen to 24, or little more than half, the number of pauper patients maintained being practically the same at both periods.

The payments of the private patients in the York Lunatic Hospital in 1874 averaged £1 6s. 6d. a week, while in 1884 they had increased to £1 11s. 8d.

In view of these facts it certainly seems unfortunate that “the Secretary of State has, *not upon the recommendation of the Commissioners*, approved an extension of the contract for the reception of the city paupers until 1889.”

The Commissioners do not appear to have been more successful as regards this hospital in securing attention to another suggestion which is scarcely less important, and which they have repeated upon many occasions. We refer to the appointment of an assistant medical officer. We believe this to be the only Lunatic Hospital containing so many as 100 beds in which the whole of the medical charge is left in the hands of a single resident officer, and it is a fact which is certainly not creditable to those who are responsible for its general management. They cannot even plead a depressed state of the finances of the hospital, which are evidently flourishing.

The average weekly cost per head in County and Borough Asylums in 1884 was as follows:—

	County Asylums.	Borough Asylums.
	£ s. d.	£ s. d.
Provisions (including malt liquor in ordinary diet)	0 4 0 $\frac{1}{2}$	0 4 3 $\frac{1}{2}$
Clothing	0 0 8 $\frac{1}{2}$	0 0 9 $\frac{1}{2}$
Salaries and Wages	0 2 2 $\frac{1}{2}$	0 2 5 $\frac{1}{2}$
Necessaries (<i>e.g.</i> , fuel, light, washing, &c.)	0 0 11 $\frac{1}{2}$	0 1 3 $\frac{1}{2}$
Surgery and Dispensary	0 0 0 $\frac{1}{2}$	0 0 0 $\frac{1}{2}$
Wines, spirits, porter	0 0 0 $\frac{1}{2}$	0 0 0 $\frac{1}{2}$
Charged to Maintenance Account:		
Furniture and bedding	0 0 5	0 0 5 $\frac{1}{2}$
Garden and farm	0 0 6 $\frac{1}{2}$	0 0 4 $\frac{1}{2}$
Miscellaneous	0 0 3 $\frac{1}{2}$	0 0 9 $\frac{1}{2}$
	0 9 3 $\frac{1}{2}$	0 10 6 $\frac{1}{2}$
Less moneys received for articles, goods, and produce sold (exclusive of those consumed in the Asylum) ...	0 0 3	0 0 2 $\frac{1}{2}$
Total average weekly cost per head	£ 0 9 0 $\frac{1}{2}$	0 10 3 $\frac{1}{2}$

The entries made by the Commissioners at their visits to the various classes of asylums, which are reproduced in this report, give assurance that the care and treatment of the insane in this country are generally satisfactory, and reflect much credit alike upon those who are in immediate charge of them, and upon the Lunacy Department which is responsible to the public for the proper supervision and good government of the institutions which are under its surveillance. Pathological investigation is fairly well prosecuted, the proportion of post-mortem examinations to deaths having been 69 per cent. Medical treatment is not overlooked. Means of occupation and amusement are for the most part amply supplied, and restraint and seclusion very sparingly adopted.

In this connexion we venture to take exception to the continued inclusion, under the head of "restraint," of the wet pack, which appears to us to deserve that designation no more than a bath in which the patient is compelled to remain in the water, or the holding down of a patient during a fit of violence or excitement, or while being forcibly fed. We think that it has a tendency to limit the adoption of what has been proved to be a valuable means of medical treatment.

Towards the end of a very interesting and practical report the Commissioners relate the particulars of an inquiry by them into a series of allegations contained in three articles in the "*Pall Mall Gazette*" entitled: "*My Experiences in a Lunatic Asylum.*" From their conclusions a fair estimate may be formed of the true value of such sensational attempts to inflame the public mind upon the already more than sufficiently discussed question of asylums and the treatment of their inmates.

We give the remarks of the Commissioners in full:—"A man described in the certificates for his admission as Charles George Hawkes, of Café du Parc, Bruges, Belgium, student. He was admitted into Camberwell House, feigning insanity, upon the order of a confederate, describing himself as Ernest Lawne, chicory merchant, of 6, Pump-court, Temple, 'his cousin,' on the 19th August last, at 11.30. p.m. He was discharged 'not being insane,' on the 22nd August, upon the authority of the same person. He shortly afterwards obtained the insertion in the '*Pall Mall Gazette*' newspaper of three articles, written anonymously by himself, and

entitled, 'My Experiences in a Mad House,' in which he professed to give a true narrative of matters which he saw and heard as a patient during his stay at Camberwell House. In this narrative he charged the medical men who had certified to his insanity with unwarrantable statements, and he also charged certain attendants in Camberwell House with serious assaults upon male patients, and likewise made other complaints of his own treatment while in the house.

"Upon inquiry we ascertained that this writer was a journalist named Charles George Payne, of 6, Pump-court, Temple. Two members of our Board thereupon held an inquiry at Camberwell House into the charges. They examined, upon oath, Mr. Payne himself, and several other persons, and they came to the conclusion that his charges were not so far substantiated as to justify the Board in directing the prosecution of any person; that all his charges were, in truth, more or less exaggerations, and that there was no ground for any special action on our part beyond an intimation to the proprietors of Camberwell House that an attendant (named in the report) should be no longer retained, since his fitness for his post was doubtful. This attendant had been charged by Mr. Payne with 'boisterous fun' only; he was called upon to resign, and left. Between the statements made by Mr. Payne in the newspaper articles, and those made by him on oath before the Commissioners, there was much discrepancy, and we felt that it would be useless to adopt any criminal proceedings founded on his testimony. He admitted, *inter alia*, at the inquiry, that when leaving Camberwell House he thanked the authorities there for his care and treatment, and never mentioned to them the assaults he subsequently described in the newspaper."

Twenty-seventh Annual Report of the General Board of Commissioners in Lunacy for Scotland. Edinburgh, 1885.

The total number of registered lunatics in Scotland on 1st January, 1885, was 10,918, including 53 persons in the lunatic department of the general prison at Perth, and 238 imbeciles in training schools.

The whole increase of registered lunatics during 1884 was 169, of which number 23 were private and 146 were pauper patients. Imbeciles in training schools are registered separately, and there was an increase of 10 pauper patients in such establishments.

The increase during 1884 is 45 less than that of the preceding year.

The changes in the distribution of the insane during the year were as follows:—

In Royal and District asylums there was an increase of 36 private patients, and an increase of 30 pauper patients. In private asylums there was a decrease of 15 patients. In parochial asylums there was an increase of 37 patients, and in the lunatic wards of poorhouses an increase of 29 patients. In private dwellings there was an increase of two private and of 50 pauper patients,

The following paragraph is quoted from page xi of the Report:—"The details which most deserve special notice among the results for the year are as follows:—(1) There is a total increase of 96 in the number of registered pauper lunatics in asylums and other establishments during the past year; (2) there is an increase of two in the number of private and of 50 in the number of pauper lunatics accommodated in private dwellings; (3) all pauper lunatics continue to be provided for in public establishments." How the second and third of these statements can be correct it is difficult to imagine. If, on the 1st of January, 1885, 1,861 pauper lunatics were provided for in private dwellings, how is it possible that at the same date all pauper lunatics were provided for in public establishments? Establishments do not include private dwellings, but only Royal, district, private, and parochial asylums, lunatic wards of poorhouses, training schools for imbeciles, and the lunatic department of the general prison. That the statement, that all pauper

lunatics continue to be provided for in public establishments, means something, is highly probable, since it has been put forward as one of the details deserving special attention, in each report, for several years past. To the ordinary reader, however, the two statements appear to be directly contradictory.

During the year 485 private and 2,093 pauper patients were admitted to establishments, showing an increase of 23 in the private class and a decrease of 52 in the pauper class, as compared with the admissions of 1883. Transfers from one establishment to another are not reckoned as admissions.

The number of voluntary patients remains nearly unchanged, and their condition has been satisfactory.

The percentage of recoveries on the admissions for the year is 40·5, including both private and pauper cases. That of last year was 27·2. This great difference arises from the fact that the recovery rate in private asylums has in 1884 amounted to 71 per cent., while in 1883 it was only 11 per cent. On reference to the table detailing the numbers of admissions and recoveries in private asylums, it is found that there have been only eight males and thirteen females admitted, and that seven males and eight females have recovered. These numbers yield a recovery rate of 87·5 per cent. for males and 61·5 per cent. for females. The number of patients discharged unrecovered was 140 in the private class and 440 in the pauper class.

The death rate on the average number resident in all classes of establishments was 7 per cent. for private patients and 8·1 per cent. for pauper patients.

The removal of patients on statutory probation—that is, their removal for a longer period than 28 days—is again urged, and the Board expresses regret that application for this probationary discharge is not more frequently applied for. It is not to be wondered at, however, that superintendents are not eager to add to their responsibilities in this way, for it must be a very doubtful case indeed, where the relatives of the patient are unable to decide in four weeks, whether they will be able to take care of the patient or not.

The changes among attendants have been 519 as compared with 603 in 1883. In one asylum, between the 29th of June, 1883, and the 11th of March, 1884, 15 attendants resigned and four were dismissed; thus in the space of nine

months 19 attendants, in a staff probably of about 40, have been changed. Such frequent changes in the staff of an asylum are a great hindrance to its prosperity, and must act very prejudicially on its inmates. Would it not be useful to publish in the report a table enumerating the changes among attendants in each asylum, and thus to show where the changes were most frequent?

In their remarks on the present condition of the various establishments, the Board directs attention to the overcrowding of nearly all the Royal asylums. The Glasgow Royal Asylum and the Crichton Royal Institution appear to be the only exceptions. In the Murray Royal Asylum no pauper patients are received. This overcrowding of Royal asylums by pauper patients is much to be regretted, as it greatly increases the difficulty of patients with small means obtaining asylum treatment without coming on the pauper roll.

The average daily cost per head for pauper lunatics has been in Royal and district asylums and in parochial asylums 1s. 5d., in lunatic wards of poorhouses 1s. 1 $\frac{1}{4}$ d., and in private dwellings 9 $\frac{3}{4}$ d., giving an average for all classes of 1s. 3 $\frac{3}{4}$ d., or one farthing less than the average cost of the previous year.

The proportion of pauper lunatics in asylums decreased in 1883 to 185 per 100,000 of the population, from 188 per 100,000 which was the proportion in 1882, and although there is no further decrease, still there is no increase, the proportion being again 185 per 100,000.

The increase in the number of lunatics in Scotland since January, 1858, amounts to 5,095, and this increase is chiefly due to the larger number of pauper lunatics. The increase in the number of private lunatics, especially if only the patients in asylums are considered, is little more than is accounted for by the increase of population of the country. The enormous increase among pauper patients is found to have occurred nearly entirely among those resident in establishments, not among those in private dwellings. The natural increase of the number of pauper patients in establishments, due to the increased population of the country since 1860, would be 916. The increase has actually been 3,795. In explanation of this the Board says:—"This increase is undoubtedly due for the most part, if not altogether, to the action of legislative enactments, such as the lunacy

law and the poor law, to the action of the Government grant for pauper lunatics, to the increasing tendency in recent times to treat as lunatics those who suffer from the less pronounced kinds of mental weakness or perversion, and to the greater facilities that are afforded for obtaining care and treatment for them in special institutions."

The increase of the number of patients admitted into and resident in establishments has varied greatly in different localities, and this variation is specially investigated in the report. To aid in this investigation the counties are divided into two groups, a highland group and a lowland group.

In the highland group the average number admitted per 100,000 of population, in the period 1860 to 1864, was 17, the number resident was 92. The corresponding numbers for the lowland group were 34 and 108. In the period from 1880 to 1884 the number admitted from the highland group was 50, and the number resident 225. In the same period the number admitted from the lowland group was 54, and the number resident 166. The great increase in both admissions and residents in the highland group, as compared with the lowland group, is, to a considerable extent, explained by the absence of asylum accommodation in the highland counties at the earlier period, and by the great difficulty there then existed in transmitting patients to asylums, whereas now asylums have been provided, and transmission of patients to them is easy.

Another great cause of the increase in the numbers resident in the highland counties is the longer average period of residence. The average period of residence is four and a half years in the highland counties and three years in the lowland. This longer period of residence in the highland counties is explained by the higher proportion of ordinary paupers on the poor-roll in these counties. In small towns and rural districts the average length of time for an ordinary pauper to remain on the poor-roll is five years, while in the principal towns it is only a year and a quarter. The number of ordinary paupers added to the poor-roll is less in the rural localities, and the number on the roll at one time is much greater. The opinion arrived at is that—"it may be inferred from this that it is to the social conditions which lead to pauperism of all kinds being a more enduring condition in rural than in urban localities, that the fact that pauper lunatics are less frequently removed from asylums in rural districts is to be attributed."

Of the pauper lunatics in private dwellings in 1860, 1,432 resided with relatives and 415 with strangers; of those in 1885, 935 resided with relatives and 926 with strangers. The class of patients residing with relatives is very different from the class boarded out with strangers. The names of patients in the former group would never come on the register of the Board if they were not paupers. But while the number boarded with strangers has largely increased of late years, the policy of the Board has been to transfer patients for whom asylum treatment is no longer necessary, to friends rather than to strangers. From 1860 to 1875 there was a steady decrease in the number of pauper lunatics resident with relatives. In 1875 the Government grant was instituted, and since then there has been a steady increase, particularly in the highland counties.

The policy of the Board with respect to the boarding out of patients in private dwellings is as follows:—"It is sufficient here to say that the policy of the Board, of which the boarding out has been an outcome, has been to discourage the unnecessary or needlessly prolonged removal of pauper lunatics from the position which they would naturally have occupied if they had been sane; and where such removal is required, either for their own welfare or the public interest, to prevent the restrictions and other circumstances of the treatment from interfering more than is necessary with their natural mode of life. With this view we have striven to prevent the unnecessary or inconsiderate removal of patients from their own homes, to encourage as far as possible the abatement of the prison features of asylums, and to stimulate the relegation of patients to their homes when asylum treatment ceased to be beneficial. In accordance with this we have encouraged the transference of patients in asylums, for whom asylum treatment had become unnecessary, to the houses of strangers in their own position in life, but only when no relatives could be found able and willing to take efficient care of them. In this way the boarding out has had the effect of diminishing the demand for further asylum accommodation, and has permitted a considerable number of pauper lunatics to live in a way little removed in its character from the mode of life which they would have led had they not suffered from insanity."

The changes in the numbers of patients in private dwellings since 1860 are seen most readily in the following table:—

On 1st January.	Number of Pauper Lunatics in Private Dwellings.					
	With Relatives.			With Strangers.		
	Highland Selected Counties.	Lowland Selected Counties.	Whole of Scotland.	Highland Selected Counties.	Lowland Selected Counties.	Whole of Scotland.
1860	479	558	1,432	91	180	415
1865	392	446	1,168	98	205	441
1870	328	358	986	102	230	483
1875	290	313	843	108	301	544
1880	346	294	855	133	278	560
1885	381	310	935	174	538	928
Increase since 1860... ..	—	—	—	83	358	511
Decrease since 1860... ..	93	248	497	—	—	—
Percentage of Increase or Decrease ...	20	45	35	91	199	123

From this table it will be seen that after 1875 the effect of the Government grant was to increase the number of patients resident with relatives, numerous ordinary paupers being placed on the register to secure the allowance. Of patients boarded with strangers the great majority have been inmates of asylums, and their removal to private dwellings has, in a great measure, been due to the policy of the Board. The great increase in the number of pauper lunatics boarded with strangers during the period 1880 to 1885 shows that the Board have already been successful in some districts in carrying their views into effect, but to secure and extend this system of providing for harmless and incurable lunatics it is necessary that the Board should secure the co-operation of the parochial authorities, of the asylum medical officers, and of the inspectors of the poor. As yet only a few parishes have adopted this means of saving their asylum accommodation; but as many asylums are becoming overcrowded, extension of asylum accommodation or boarding out will soon become a necessity.

It is pointed out that for this system to be carried out efficiently a sparsely inhabited district is not necessary, in so far as that, with the exception of Inverness, all the parishes

which have successfully adopted it are in the lowland counties.

The reports of the Deputy-Commissioners refer to the condition of patients living in private dwellings only. All such patients are visited once each year by a Deputy-Commissioner, and where any considerable number reside in one district they are visited twice in the year. A short paragraph from each report will serve to indicate the opinion of the Deputy-Commissioners as to the condition of the patients whom they inspect. Dr. Fraser says:—"As regards the great majority of the insane in private dwellings in my district, I have not the least hesitation in saying that they are adequately and suitably provided for; that their general condition is a satisfactory one; that they enjoy a more rational, normal, and healthy life than any institution could afford them; that they are satisfied with the arrangements made for their care and comfort; and that they would not exchange their domestic and other privileges for any other treatment of which they may have had experience. The evidence of the correctness of these views lies in the low mortality which exists among the boarded-out insane, their good health and good physical condition, the rarity of accidents among them, and their general contentment."

Dr. Lawson says:—"I have already said that I have now visited the whole of my district six times in succession. Some portions of it, where there are considerable aggregations of patients in specially licensed houses, I have visited twice yearly, and, taking one portion of the district with another, I believe that the standard of comfort amongst the pauper lunatics in private dwellings has increased during the course of these six years."

While it must be highly gratifying to the Board to be able to publish such favourable reports of the progress of their system, these reports would appear much more satisfactory to others interested in the treatment of the insane, and would be much more instructive, if they contained a greater number of details concerning the patients boarded out. Thus, a table showing the form of mental disorder from which the patients suffered when removed from the asylum would be of value, as also would be a table showing the form of mental disorder of such patients as were returned to asylum treatment. Nowhere in the report can there be found a table of the causes of death. This is a most undesirable omission, and reference to a table furnished in the previous annual report, detailing the causes of death for the years 1880, 1881,

and 1882, is not reassuring. Thus, three deaths were caused in that period by maniacal and melancholic exhaustion. That such deaths occurred among pauper lunatics in private dwellings appears to indicate a want of sufficient supervision, for it is difficult to conceive how the constant nursing and medical treatment necessary in such cases could be obtainable in the private houses of the class of people with whom such patients are boarded. In nine cases the cause of death was unknown. Does this mean that in these cases no medical assistance was obtained during their fatal illness?

Another detail on which little or no information is to be obtained from the report is the number of accidents occurring among the boarded-out patients. In the Commissioners' entries at the various asylums serious accidents are nearly always enumerated, but among the boarded-out the rarity of accident alone is mentioned. Other points on which it would be interesting to have information are the frequency of the causation of really serious injury to person or property by these patients, and the frequency with which their sexual propensities give rise to untoward results.

Instead of such details, Dr. Fraser furnishes a "Sketch of the Development of the Private Dwelling System in Scotland." Little more than the headings of the various sections in this sketch is necessary to indicate its aim and scope. The first section shows that lunatics are disposed of in private dwellings in all countries, though they are not everywhere under efficient supervision. The next five sections point out that the Scotch Lunacy Act for 1857 did not contemplate the organization of a system of providing for lunatics in private dwellings, but that the views arrived at by the officials of the Board in the discharge of their first duties after the passing of that Act, led to the organization of this system, which is now a marked feature of the Scotch Lunacy Administration; and further, that the Amendment Acts of 1862 and 1866 reflected the views of the Board, and made care and treatment in private dwellings a definite and important part of the work of the Board. This being so, the Board's work and policy have influenced the number of these patients in various ways and to a considerable extent.

The following table, copied from this part of the report, is at first sight very misleading. From the table as it stands it would appear that 43·3 per cent. of the total insane were in 1859 in private dwellings, and 80·8 per cent. in 1885, giving an increase of 37·5 per cent. for the period. The real

figures are 9·1 per cent. resident in 1859 and 14·2 per cent. in 1885, giving an increase of 5·1 per cent.

PARISH.	On 1st January, 1859.			On 1st January, 1885.			In-crease.	De-crease.
	Total Insane.	In Private Dwellings.		Total Insane.	In Private Dwellings.			
		No.	Per Cent.		No.	Per Cent.		
City, Edinburgh ...	196	8	4·8	238	63	26·4	21·6	—
Govan and Gorbals ...	40	1	2·5	307	65	21·1	18·6	—
City, Glasgow ...	293	23	7·8	501	64	12·3	4·5	—
St. Cuthbert's and Canongate ...	183	25	13·6	375	65	17·3	3·7	—
Barony ...	151	22	14·6	512	19	3·7	—	10·9
	863	79	43·3	1943	276	80·8	48·8	10·9

Nothing of any interest is to be found in the rest of Dr. Fraser's report, and the whole Sketch is merely a defence of a system which, if adopted and carried out with care and moderation, is useful and valuable, but which may easily be rendered a source of danger to both patients and the public, by over-zeal on the part of its adopters.

Dr. Lawson, in his report, furnishes tables which offer a "comparative statement of the comfort and cost of pauper lunatics under domestic care." Each of the counties visited by Dr. Lawson is dealt with separately, and the following table for the county of Ayr will illustrate the method adopted:—

COUNTY.	Bad.		Avge. Allow- ance.	Mid- dling.		Avge. Allow- ance.	Good.		Avge. Allow- ance.	Very Good.		Avge. Allow- ance.	Tl.	Avge. Allow- ance.
	M.	F.		M.	F.		M.	F.		M.	F.			
Ayr.			s. d.			s. d.			s. d.			s. d.		s. d.
Alone ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—
With Strangers	—	—	—	—	—	—	4	6	5 0	1	2	5 5	13	5 1
With Relatives	—	—	—	2	3	4 0	4	16	3 10	4	3	4 5	32	4 0
In S. L. Houses	—	—	—	—	—	—	4	2	4 9	—	—	—	6	4 9
Totals ...	—	—	—	2	3	4 0	12	24	4 4	5	5	4 9	51	4 4

The following table, compiled from the tables similar to the above, shows the influence on guardianship of the presence or absence of family relationship :—

	Bad.	Middling.	Good.	Very Good.
1. Under Unrelated Guardians—				
<i>a.</i> As Single Patients ...	3	12·4	53·8	30·8
<i>b.</i> In Specially Licensed Houses...	—	2·3	72·6	25·1
<i>c.</i> Combined ...	0·9	7·2	63·7	28·2
2. Under Related Guardians ...	4·1	15·7	58·4	21·8
3. Alone ...	—	—	78·6	21·4

Commenting on this table, Dr. Lawson says :—“It will thus be seen that the best provision for pauper lunatics in private dwellings is that which exists in specially licensed houses. It is remarkable, however, that the largest proportion of strikingly satisfactory cases is found in dwellings where one patient is the sole charge of an unrelated guardian; while, on the other hand, the largest proportion of distinctly unsatisfactory cases occurs among the patients who are in the keeping of their own relatives.” This fact has been recognised in the article on Gheel in the present number of the Journal.

The rate of board paid for lunatics in private dwellings is evidently becoming a question of vital importance to the Commissioners, and is dwelt on at some length by Dr. Lawson. He is of opinion that from seven to eight shillings a week should be the maximum charge, but that in addition, all that is required in cases of illness should be provided. The actual condition of affairs, in one district at least, may be inferred from the following paragraph quoted from the report of a Scotch superintendent :—

“It is the question of keep—the difficulty of obtaining it at first at a sufficiently low figure, and the immediate demand for an unobtainable increase—which threatens obstruction, and appears most likely to prove a real hindrance to the obtaining of room for the treatment of cases not actually ailing. Ten shillings, and, I am told, twenty shillings a week has been refused. No wonder, therefore, that the initial seven shillings or eight shillings a week is soon reported as insufficient, and under threat of a break in the bargain a new and more highly paid one is demanded, and

has had to be conceded, otherwise replacement in the asylum offered the only outlet. And it is well to have in mind also that demented and chronic lunatics often possess vigorous—nay, gluttonous—appetites, requiring, as I have been pitifully told by an applicant for an increase to her weekly dole, an egg or ham and egg to breakfast and meat to dinner for satisfaction. Thus it may well be feared we have a long and painful journey to travel, as well as a bitter experience to undergo, ere we arrive at that higher and happier civilization some of our neighbours are boastfully said to have attained to, which regards the introduction of an alien and a lunatic into the family as an advantage and a boon.”

The Blot upon the Brain. Studies in History and Psychology.
By WILLIAM W. IRELAND, M.D. Edin.

The work consists of thirteen distinct chapters, as follows:—(1) On Hallucinations. (2) The Hallucinations of Mohammed, Luther, and Swedenborg. (3) The Character and Hallucinations of Joan of Arc. (4) The Hereditary Neurosis of the Claudian-Julian family, of Mohammed Toghlac, Sultan of India, of Ivan the Terrible of Russia, and the Romanoffs. (5) The Hereditary Neurosis of the Royal Family of Spain. (6) On St. Francis Xavier. (7) On Fixed Ideas. (8) Folie à deux. (9) On Unconscious Cerebration. (10) Thought Without Words and the Relation of Words to Thought. (11) Left-handedness and Right-headedness. (12) On Mirror-writing. (13) On the Dual Functions of the Double Brain.

Several of these papers will be already familiar to our readers, and to the readers of “Brain.” A part of the paper on Xavier was reprinted from the “Quarterly Review,”

It is always well to get the unpleasant part of a review over first. To begin, then, we cannot think that Dr. Ireland has been happy in the title he has chosen. The title conveys no particularly distinct idea in itself, and to the controversial chapters, such as the one on Unconscious Cerebration, it does not apply. To many of the others it only applies incidentally where isolated examples of mental perversion may be chosen in illustration of a particular theory. We cannot think it sufficient that he should cite the poet-laureate as an assumed authority. Again, a blot is a thing

wholly a blot, wholly black and differing from the surface which it spoils. It has no white nor dark side. But if morality be the highest test of the value of life, the blot of sense-perversion—sense-perversion which admittedly may be unaccompanied by illusions or hallucinations of belief—may in one sense have both a white and a dark side. It is scarcely open to question that much if not all of the greatness of the great men and women, such as Socrates, Joan of Arc, Pascal, Swedenborg, referred to by the author, was owing to the peculiar form of sense-perversion which led their lives into a new channel from the first. *Folie imposée*, as Dr. Ireland might perhaps choose to term the influence their lives have left behind, in defence of his title. But this is in truth the white side of the blot, just as the dark side is to be found in the lives of Caligula and Nero, and Agrippina the mother of Nero, and Ivan the Terrible. May not the benefits to humanity conferred by the former, the ethical legacy of Socrates, the heroism of Joan, the dispersion of the old-world theological fallacies to be gained from an unbiassed study of Swedenborg, be justly weighed against the horrors and atrocities perpetrated by the latter?

Again, *apropos* of Mohammed, we need not remind Dr. Ireland that the whole question of religious inspiration is closely allied to that of hallucinations—hallucinations of which the ultimate source, as Brière de Boismont says, “must always remain hidden”—a fact which, in our opinion, might perhaps have suggested to him, out of courtesy to his possible opponents, a little less trenchant title for his work.

“Dans l’antiquité,” writes Brière de Boismont, in the preface to the third edition of his learned work, “des Hallucinations” (Paris, Baillière, 1862), “Socrate le promoteur du dogme de la Providence, le fondateur de la morale; au moyen âge, Jeanne d’Arc l’héroïne populaire et la libératrice de la France; dans les temps modernes, Pascal le penseur sublime, l’éternel honneur *de la raison*” (the italics are our own) “déclarés fous, hallucinés au nom de la physiologie du cerveau que nous savons si bien, telle est l’origine de ce livre.”

Perhaps the Frenchman is a little grandiloquent, but he is also a little—shall we say—more considerate than Dr. Ireland, in his manner of approaching the subject.

But so far we may go with our author as to admit the inevitable *lusus naturæ* implied in insanity and all allied phenomena and if the brain be but the passive instrument of the *ego*, as we ourselves are in the habit of supposing, no one can feel

aggrieved at condemnation which is at least purely of a physiological character.

The opening sentence of the first chapter rather surprised us. In Mr. Sully's work on Illusions, which, to our mind presents the most complete and comprehensive summary of all mental errors, we do not remember to have observed any class characterized as "delusions of the senses." We do not say that the term is bad; it may well be used, *e.g.*, to express those states of mind where chronic sense-perversions are productive of, and associated with, illusions of belief, but the term should not have been introduced without an explanation of what it was meant to imply.

In the opening chapter on Hallucinations, we think that the author has adopted a too externally peripheral treatment of causes. The five causes of hallucination, as given by Griesinger, are (if we remember rightly), as follows:—

- (I.) Morbid emotional states.
- (II.) The outward calm between sleeping and waking.
- (III.) The action of drugs, such as "hachisch."
- (IV.) Profound mental depression.
- (V.) Special diseases of the organs of sense.

Of these it will be seen that only one relates to the external periphery. A number of other special causes might be quoted; all would tend to indicate the demand for psychic and psycho-sensorial, rather than purely sensorial investigation.

The types selected by our author, such as Swedenborg and Joan of Arc, seem specially to demand it. The main issue of their cases cannot at all be justly estimated without it.

We are inclined to think that the omission results from our author's modesty, or from his unwillingness to enter the wider philosophical and controversial arena implied by such investigation; certainly not from his ignorance of the points at issue, or want of psychological acumen.

That he is aware of the truth of what we have said appears from the following passage (page 30):—

In those cases where the conception in the mind precedes the hallucination, we may suppose that the wave of irritation commences in the brain and descends downwards to the sensory tracts, and even to the extremity of the sensory nerves. Having been first realised as a mental image, on passing down to the sensory region it appears as a sensory impression, in the optic tract as a spectre, in the auditory tract as a sound, and so on. . . . The exact conditions under which this takes place are not known to us. . . .

A very candid admission, but it is here that investigation is required. Instead of quoting, as the author has done in this chapter, cases from the works of Baillarger, de Boismont, and others, we think he should have given us the benefit of his opinion as to the *ultimate source*, the primordial causation of these phenomena. We notice, however, here and there, a very shrewd remark bearing on the question. Take the following from the chapter on the Dual Functions of the Double Brain (p. 317):—

Those who hold that epileptic fits have their point of departure from irritation of the grey matter of the brain, have a difficulty in showing how the excitement arising from any injury to one hemisphere is propagated to the other hemisphere, so that the spasms in regular order affect one side of the body after the other, and the disturbance passes to the uninjured hemisphere, involving total unconsciousness.

Do not these facts seem to indicate an origin for the epileptic furor, and perhaps also for the hallucinations which accompany it, nearer to the *ego and dynamically prior in controlling power* to the reflex or automatic action of either hemisphere? But where that may be it is not for us here to express our opinion.

If the author had devoted his attention to this point, he would not in all probability have had to make the candid confession of his inability to advance a plausible theory in reference to the hallucinations of poor Joan. "The great difficulty of course," he says (page 74), "is to give a rational explanation of her early delusions, which seem to be connected with hallucinations of hearing and sight. I cannot say that I have any clear explanation to give."

The fact that Dr. Maudsley has written articles upon Swedenborg should not, in our opinion, have precluded Dr. Ireland from giving us the benefit of his careful consideration of this, at least, the most remarkable case of hallucinations on record. The method pursued by Dr. Maudsley in the articles to which Dr. Ireland refers, seemed to us when we read them to be according to one of the cardinal principles of military tactics—viz., to concentrate all your forces upon the weakest point of your opponent's position. In warfare, perhaps in politics, such a course may be advisable—justifiable even. But to calm investigations in search of truth, it is wholly inapplicable, and it may be much worse. It displays preconceived judgment, formed rather from personal *animus* than from the investigations themselves. It is therefore a

sign of weakness. Now, from this weakness, at least, we will say that Dr. Ireland, throughout the whole of his faithful and laborious work, is wholly free. Never do we remember to have met with any thinker who displays a nobler and more reliable power of calm and unbiassed philosophical investigation. Let us all give him credit for this high quality. We feel sure that if he should in the future care to devote his attention to the subject of Swedenborg, whatever he may write will be read with interest and profit. But to those who, for any purpose, have been careful students of the life and writings of Swedenborg, his manner of skimming over the subject in the present volume will certainly prove anything but satisfactory.

Perhaps he will allow us to suggest that, if he will follow the method indicated by us, he will arrive at a more satisfactory conclusion than he did with regard to Joan.

And now we have done with fault-finding. To the work, as a whole, we have nothing but praise to give. The extensive and accurate research displayed in the historical papers, together with the author's judicious and highly interesting choice of facts throughout; the profound acumen and care evident throughout every page of psychological analysis, are sufficient to render this work valuable both to the general reader and the specialist in mental physiology. The later chapters abound with a most interesting, and in many cases, new collection of pathological facts. Of the historical papers, perhaps the most interesting after all is that which relates to Joan. The sad story of her life of heroism is excellently and truthfully told. How she was born at Domremy, and as a child was sent to keep sheep. How at thirteen years of age she first heard "a supernatural voice," from which time she was continually urged by her voices to proceed to the seat of war and deliver her country from the invader. She saw visions, St. Michael and others. "I saw them," she said to the judge, "with my own eyes, as plainly as I see you; and when they retired from me I wept, and much I wished that they would take me with them." Then came her triumphant entry into Orleans with her soldiers. The events that follow are known to all—how success followed success, until the Dauphin was crowned at Rheims. Joan "preserved her virginity, she tried to discourage gambling, would not suffer profane language, and had the credit of getting la Hire to give up swearing." Then the scene changed; she was wounded, fortune forsook her, she

became unsuccessful, she was persecuted, she was betrayed. She was taken prisoner, she was insulted by the English, and forsaken by those to whose service she had devoted her life. She was maltreated, she was tried and condemned, she was burnt alive as a witch. "The voices reproached her for her abjuration, and said that she ought to have resisted to the last." Though Dr. Ireland has no explanation to offer, our readers will find the story of Joan's life told in the most graphic and interesting manner throughout.

Whether the knowledge of evil be in itself an evil, is a point open to argument; the insanity of power as described in the history of the Claudian-Julian family, to say the very least of it, is a sufficiently revolting picture. The author refrains from quoting the stock classical extracts, and gives us an original and interesting narration of the depravities of those times. But even these are impaired by the terrible string of atrocities perpetrated by Ivan, whose last deed, as all the world knows, was to slaughter his own son. When years ago we chanced to find ourself for a short time in the holy city of Moscow, we remember having our attention drawn to a curious little niche in the Kremlin where Ivan was wont to show himself to his subjects at times; and we remember bumping our head against the low doorways of the seven-cupola'd church, the eyes of whose architect, we were informed by the Polish *valet de place* who condescended to chaperon us, Ivan had caused to be put out, in order that he might not build another so well. This comparatively unimportant fact is not, we think, thought worthy of mention by Dr. Ireland; but the atrocities which are related by him do surpass in horror everything we had previously conceived, from hearsay or history, of Ivan. Ivan must assuredly have been a blackamoor, in whom the heredity of blackness was so strong that it is doubtful whether he could ever have been washed white in time. There is no whiteness whatever in this part of "the Blot," at any rate.

The Spanish chapter is quite a relief, coming after the portraiture of such horrors as these. Why did not Dr. Ireland tell us a little about Philip the Second, and the eccentric building of that curious Escorial? There is one little tit-bit here which we cannot refrain from quoting. It was proposed to marry Juana, the daughter of Ferdinand and Isabella, to Henry VII. of England. We learn that the King was willing to marry Juana whether sane or insane, *especially as it was*

understood that her derangement would not prevent her bearing children! Dr. Ireland quotes De Puebla as his authority.

There is no king in the world who would make so good a husband to the Queen of Castile as the King of England, whether she be sane or insane. If the insanity of the Queen should prove incurable it would perhaps not be inconvenient that she should live in England. How thoughtful of those Spaniards! The English seem little to mind her insanity, especially since he has assured them that her derangement of mind would not prevent her from bearing children.

Henry VII. seems to have been rather hard up for a wife, almost so much so as to give us reason to suppose there might be some hereditary warrant for the wife-mania which manifested itself so remarkably in Henry VIII., his son. But, seriously speaking, it would of course be difficult to say what conclusions we should be entitled to draw from the above facts as to the life at Court in those days.

No one who is accustomed to think, or write, or speak much about hereditary disease, should be without Dr. Ireland's book, as it abounds with most interesting and remarkable historical facts which will be found exceptionally useful.

To turn our attention to the case of St. Francis Xavier. It will be remembered that the miraculous preservation of the dead body of this remarkable apostle to the Indies, who lived in the early Jesuitical times, has always been regarded as one of the best-attested miracles of the Roman Catholic Church. Dr. Ireland collects the different lesions noticed on the body as follows, giving in each case his authority:—

(I.) There was a cut in the thorax over the region of the heart (Dr. Cosmo Sairania.)

(II.) A cut in the abdomen (Ambrose Ribera, Inquisitor).

(III.) A piece cut from thigh (Ribera and Bonhours).

(IV.) A piece cut from arm (Nunez).

(V.) Sundry bruises on the body (Nunez).

(VI.) Effusion from face (Bartoli).

(VII.) Effusion from both shoulders (Tursellinus).

And then he sums up as follows:—

Granting that the Inquisitor, in his hasty examination, mistook the abdomen for the chest, and that there was thus only one wound in front of the body, there is still enough to show that the thing was done more clumsily than needs have been. We may therefore prefer to believe that the body had been embalmed to the assumption that the laws of chemical decomposition were miraculously suspended in the case of the remains of Francis Xavier.

We think most of our readers will agree with Dr. Ireland.

We regret that we have no space left in which to notice the remaining interesting papers, or to enter into the controversy respecting the nature of what has been termed "Unconscious Cerebration." Our readers must procure the work for themselves, and whether they agree with Dr. Ireland's views or not, they will assuredly derive considerable benefit from the new and deeper lights of investigation which he throws everywhere upon the points at issue. The papers on "Wordless Thought," and "The Relation of Words to Thought," are especially worthy of prolonged consideration. But, alas! we cannot haul up "psychic manifestations," for examination from the deep seas of mind, as we may the *Bathybius*. Everything has to be done almost in the dark. Until we have a stable and recognised classification of the feelings in psychology, such questions as these will always remain of a controversial character.

The most valuable chapter from the physiological point of view is undoubtedly the specially interesting one on the dual functions of the hemispheres. This chapter abounds with most interesting illustrations from the annals of hysteropilepsy and experimental hypnotism. We cannot refrain from giving just one passage descriptive of double hallucinations, which the author translates from Bérillon:—

It is easy to produce in a hypnotised person hallucinations of sight on one side, and hallucinations of hearing on the opposite side. All that is needed is to describe an agreeable picture in the left ear, and to imitate the noise of firing in the right. Immediately the right side of the face expresses fright, while the left side still continues to express satisfaction. There exists, then, simultaneously in the brain two hallucinations of a different nature, excited by sounds applied to each ear, each hallucination occupying a different hemisphere. Otherwise it would be difficult to comprehend the opposite contractions of the face in connection with each of the hallucinations. As for the critic who says that the illusions and hallucinations brought on with hysterical patients in the somnambulistic period are merely simulated by the patients submitted to these experiments, there is only one reply to make, that it is not possible for any one, even a hysterical person, while in a waking state, suddenly to express joy on one side of the face and fear on the other.

The inductions of Bérillon are as follows:—

By certain means we can in man at the pleasure of the mesmeriser—

1. Suppress the psychical, motor, and sensory activity of one hemisphere of the brain.

2. Give to each hemisphere a different degree of activity.

3. The two hemispheres having an equal activity, we can create for each of them at the same time manifestations varying in their seat, their nature, and their character.

That is to say, the same individual may, in the hypnotised state, represent by each hemisphere a distinct being, each endowed with its own individuality.

Thus, each hemisphere being complete in itself (although in its sensory and motor action it is generally limited to one side of the body), and enjoying within certain limitations its own particular activity, one may say that man, in his mental, motor, and sensory functions, is really *double*; he possesses *two organs of ideation, two brains*.

"Yes," says Dr. Ireland, "but have we not had something like this before to demonstrate theories now as dead as the fancies of astrology?"

Dr. Ireland is thinking of the phrenology of Gall and Spurzheim, and the experiments of Dr. Elliotson, who thought that he had established it upon a secure basis.

We think that we should agree with Dr. Ireland. For there is undoubtedly a psychical *unity* underlying the duality of the hemispheres, of which the facts of hypnotism do *not* take cognizance. It is not, in fact, logical to speak of the psychical or sensory activity of a hemisphere, as Bérillon does in his first conclusion. It is a confusion of cause with effect and of effect with cause. The ordinary loose expressions of brain changes as being *concomitant* with mental activity, are equally misleading. For these also are simply associated as cause and effect, and are not co-ordinate with one another in time, as often seems to be implied in the conclusions drawn. Therefore it is surely wrong to imply that "man," the *ego*, in his "mental and sensory functions," may be a duality. And the source of the fallacy lies in the fact that conclusions are drawn and applied to man in his normal state, whereas the hypnotised man, or rather the organism which, under these conditions, represents him, is in an abnormal state. It is the same difficulty which exists in drawing conclusions from post-mortem examination of the brain, when it is impossible to show that the brain exists under the same conditions as it did during life.

Everything goes to show that the very condition of hypnotism itself is owing to a suspension of the activity and con-

trolling power of what we may describe as a psycho-substantial Unity wherever and whatever this may be.

For, anything that constitutes the self-hood of the individual himself is absent with consciousness, when he is in the hypnotic state.

The only conclusion that can truthfully be drawn from these experiments seems to us to be that in the hypnotic state, so far as there is automatic production of induced hallucinations there is duality of function.

But when the individual is de-hypnotised, when the *psychic unity* reasserts its controlling power, when consciousness returns, neither the automatism nor the duality are any longer apparent.

We must now take leave of Dr. Ireland, and in conclusion we may congratulate him upon having adopted throughout his work that judicious combination of the *style périodique* and the *style coupée* which is especially in harmony with the subjects upon which he writes: not wearying the ear with meaningless and monotonous cadences, but speaking to us conformably with the maxim of Quintilian, *non semper utendum est perpetuitate et quasi conversione verborum, sed sæpe carpenda membris minutioribus oratio est.*

W. H.

Hospital Construction and Management. By FREDERIC J. MOUAT, M.D., F.R.C.S., Local Government Inspector, &c., and H. SAXON SNELL, Fellow of the Royal Institute of British Artists. 280pp. London: J. and A. Churchill.* (*First Notice*).

Impossible as it must ever be to produce a treatise which shall deal exhaustively with a subject capable of such indefinite extension as that now before us, and so acknowledged by the joint authors of the work, whose title heads this paper, we may yet congratulate those specially interested in any form of hospital or asylum work on possessing herein so careful a record of diligent, varied, and detailed observation.

The man who should design and carry out a *complete* hospital or asylum structure (even so far only as present knowledge extends), must, we think, graduate in the schools both of medicine and architecture, for however skilful the architect, he cannot possess a constant readiness to apply

* See Journal, July, 1885.

medical knowledge, and however practical the medical man he will certainly spend money largely in excess of what is necessary to attain his immediate ends.

The plan of the book is opened by a joint preface, in which the authors show the intention of the arrangement of subjects according to their respective importance, and rightly, we think, have endeavoured to establish medical principles and requirements to which buildings and their fittings should be adapted.

The difficulty of dealing with such a work within the limits of an ordinary paper is so apparent, that we shall only attempt in this number to extract the salient features therein presented of the more perfect type of hospital building and management, reserving for a future one some remarks on the history and comparative qualities of the examples described and illustrated.

As respects the medical author's part, we are met by a large number of recommendations, based, as is incidentally shown, on a wide and practical experience.

There is no uncertain expression of opinion as to the lately much-vexed question of the immediate superintendence of the establishment.

Under the heading "Special or Executive Control" he says:—

"The immediate government of a hospital should be entrusted to a resident medical superintendent. It is so generally in the United States of America, in some of the greatest hospitals on the continent of Europe, in the most important hospitals of Scotland, and in the large and well-managed separate poor-law infirmaries of this Metropolis. To the medical superintendent all persons within the walls of the institution should be strictly and directly subordinate. There should be no concurrent, separate or conflicting authority. He should not be charged with the treatment of the sick, and should neither possess nor exercise any power of interfering with the physicians or surgeons in their treatment of cases of disease, accident, or injury. The direction of all other internal concerns should be exclusively in his hands, such as the maintenance of order and discipline, the regulation of supplies of all kinds, the custody of all appliances and instruments, and the initiation of all such structural and other changes as may from time to time be found necessary. In matters of finance and supply he should act under the orders of the special sub-committees of finance and buildings, appointed from the general governing body. He should regulate the admission and discharge of patients, and the keeping of the records of the hospital, with the aid of such subordinate staff as is always required in great institutions.

"The out-patient department should also be under his control. The appointment, removal, and distribution of all nurses, servants, and subordinates generally should likewise be vested in him, subject to the immediate control of a house committee. He and all the sub-committees should submit an account of their proceedings monthly, or as much or less oftener as might be deemed necessary, to the general committee at its appointed meetings, with whom should rest the final sanction and approval of all matters connected with the institution. The general committee should have a paid secretary to arrange and keep its records, and be the official medium of communication between that body and the officers of the hospital.

"If there be any class or kind of public institution which more than any other demands the possession of special and technical knowledge and more direct unity of authority in its immediate management, I hold it to be a hospital. A medical superintendent, from his professional training, is alone competent to gauge at once, with promptitude and decision, all the requirements of such an institution; and, as he must always be appealed to in the last resort, common-sense and the proper conduct of business of all kinds in every other walk in life, indicate that he should possess the power, in the first instance, of dealing with every such matter as pertains to the economical and efficient control of a place devoted to the healing of the sick. Fettered as he would be by his responsibility to special committees and the general committee, there would be no fear of his abusing such authority, for a swift and sure remedy could be found for such abuse. But, as a matter of fact, it is not abused in those institutions in which it is in use, as I have had abundant opportunities of seeing.

"However, even our existing system, mediæval and out of harmony as it is with the age in which we live, is better than that of the director of a French hospital, acting solely under the orders of a central official authority, which is, as stated before, about the most inefficient and mischievous form of government that I have ever seen in action."

Under the heading "Nursing" he says:—

"That skilled and trained labour is infinitely more efficient and trustworthy than unskilled and untrained labour is undeniable. But to elevate nursing into a special profession, and to arm it with independent authority in the management of disease or accident, I hold to be a mischievous mistake, alike in public institutions as in private life. It is, and must always be, from its very nature, a subsidiary function, but not the less valuable or important on that account. Neither the education nor the training of the most accomplished nurses can fit them for independent charges, nor are they intended to do so. The elementary and, of necessity, superficial acquaintance, with so much of anatomy, physiology, chemistry, pharmacy, and physics, as is now imparted to them, is an important auxiliary in their practical

training, but cannot go further in rendering them in any way independent of the physician or surgeon, under whom they are acting." "I cannot, again, concur in any scheme for connecting the duty of nursing with any form of religious or quasi-religious organization, for hospitals are open to all classes, sects, and creeds, and should be absolutely free from even the suspicion of any sectarian bias or proselytizing tendency."

When we come to the subject of "Hospital Records," a difficulty at once faces us, in seeing our way to carry properly into effect the suggestions made for collecting and summarising the results of hospital treatment. Here, however, our author is careful to guard himself in his recommendations, by accompanying them with a caution, not too strong, we think, as to the care necessary.

After pressing on our attention the advantage of numerical statistics in this special branch of human knowledge, he proceeds:—

"There is, at the same time, none other in which it is more necessary to guard against the fallacies incidental to, and, in some degree, inseparable from, this method of inquiry, in which more rigorous exactness is necessary in the collection of the facts themselves, and in which greater caution is required to avoid hasty or dogmatic deductions from mere numerical results."

Passing on to the more definite ground of the "Principles of the Construction and Arrangements of Hospitals," we find much that would, perhaps, be more properly incorporated in the architectural section of the work, but we do not doubt the advantage of having the views of a medical expert on the same points dealt with later on, though it tends to make the book slightly diffuse.

In the preliminary matters of site and surroundings certain axioms are laid down, which we venture to think not entirely practicable. For instance, "every hospital, wherever placed, should be surrounded by a zone of aeration, unencumbered with buildings or any other cause of obstruction of light and air, to a distance of at least double the height of the buildings." The question at once occurs, how in London or a large town can this be secured without going to an enormous expense? We are also told that the interspaces, in town or country, should not be paved, but should be cultivated as gardens. Is this equally true of ground which is known to be "made," and probably of doubtful composition?

Our authors are at one with each other, in giving a favourable opinion of the pavilion (or detached) system of building, as opposed to (in general) the block or many-storied system:

the advantage ascribed to the former being its freedom from contamination by exhalations from below.

In view of the known qualities of the atmosphere of London, we should have liked to see some reference made to the comparative healthiness of hospital, or asylum wards, elevated to some distance from the ground level, not merely with a dry basement, as is frequently mentioned and illustrated in this work, but boldly treated by the introduction below of premises used for different purposes, in order to gain an upper level for the sanitary work.

The well-known disinfecting properties of earth are most interestingly exemplified by an instance given of the author's experience in India.

"The Hindus of every part of India with which I am acquainted, have, from time immemorial, possessed a means of purifying the atmosphere of their rooms and tents, by spreading a light coating of a mixture of earth containing organic matters on their walls and floors, which enables them to dispense, to a considerable degree, with ordinary ventilation. The process is called 'leaping,' and is usually performed by the women of the household. With a view to submit this proceeding to a practical test, I had four cells in the Presidency Jail of Calcutta, each containing 480 cubic feet, and practically unventilated, carefully prepared. Two of them were limewashed throughout, and the two others 'leaped.' I had four healthy prisoners locked up in them at night, one in each cell. On opening the cells next morning, the two which were limewashed were stuffy and offensive, redolent of the peculiar animal odour exhaled by native prisoners in such circumstances. The two others were as fresh and as pure as if no one had slept in them. This led me, as head of the prison department, to direct the application of the principle generally in all the jails under my administrative control, so far as it was susceptible of direct application to walls, floors, and earthen beds. I also employed charcoal extensively for the same purpose—the purification of the air of prison wards from animal exhalations—and I had reason to believe, with success. This seems to me to be deserving of careful trial in Europe."

There are many general observations on the subject of ventilation and fresh-air supply, and the use of a central or general extract shaft is strongly deprecated. The tabular statements given on page 34 are interesting as showing to a certain extent what effect upon the health of the inmates the numbers contained in a building may have. The more reliable of them, quoted from Mr. Lawson Tait, have a distinct bearing on the advantage elsewhere insisted on of avoiding aggregations of sick people.

In the matter of air supply and cubical capacity required

per bed, some interesting examples are given of the practice on the continent, and although this part of the subject is more particularly dealt with in the architectural section, we may requote a part of the report of the Central Commission on the plans for the new civil hospital of Antwerp. They said:

"But after all, is it in this amount of cubic capacity (60 cubic metres per bed) that the best solution of the question of ventilation is found? With good ventilation much less space would suffice, and is it not natural to suppose that renewal in a given time is easier in a small cubical area? In the matter of ventilation it must not be forgotten that it is not only all important to give constantly pure air, but to be able to remove vitiated air as quickly as possible, without causing hurtful draughts. The processes of ventilation are not yet so perfect as to ensure full reliance; hence it is better to be a little cautious, and not to run the risk of increasing the inconveniences we have pointed out by building too great wards."

This expression of opinion is largely borne out by our own experience of both public and domestic work, in the latter of which it is now generally allowed that low rooms are as wholesome as lofty ones, provided that careful attention has been paid to the easily regulated introduction of fresh air.

In the matter of aspect, we may specially note the following extract given from the report of a French Commission, presided over by General Morris in 1865. This Commission had authority to prescribe the conditions for hospital and asylum building and management throughout France, and some of their recommendations may well find place in such a work as this, *e.g.*, "An east and west exposure of the sick wards is the most desirable." "The upper floor should always be separated from the roof by attics in which patients should not be placed;" besides others already adopted by the Chirurgical Society of France, and previously detailed.

Lying-in hospitals are discussed under a separate heading, and the necessity is shown for extraordinary care in the avoidance of any condition in the least degree favourable to the spread of puerperal fever. St. Thomas's, University College and Westminster Hospitals, in London, and the New Hôtel Dieu, the Maternité and the Clinique, in Paris, are specially mentioned as types to be avoided, whilst the Western Infirmary, Glasgow, the New York Hospital, the Johns Hopkins Hospital, Baltimore, the Friederickshein, in Berlin, and the Hospital of St. Eloi at Montpellier, are most favourably reported on.

The mention of buildings specially designed to guard against the spread of contagious diseases, or for their cure, brings us to the consideration of the advantages claimed (firstly by the medical author) for a one-storey or "hut" system of construction, and here we cannot do better than requote the late Dr. W. A. Guy on the experience of Dr. Brocklesby, an English military surgeon of the last century.

After describing the loss of life from disease amongst a number of picked soldiers, returned in 1758 from an unprosperous attack on the coast of France, and the difficulty experienced in disinfecting an old house at Newport in the Isle of Wight, he says:—

"Taught by this sad experience, and finding that the soldiers landed from the transports were more numerous than could be accommodated in all the spare out-houses, barns, and empty cottages which money could procure or humanity supply, it was resolved to erect a temporary shed with deal boards upon the open forest, to thatch it with a coat of new straw thick enough to keep out wind and rain, and to make it large enough for 120 patients. A country workman did the work (charging for the use of the boards) for £40. Here I quote Dr. Brocklesby's words," says Dr. Guy:—"Although the hovel was finished in a fashion the most slovenly, and apparently inadequate to the end proposed, upon trial it was found that, notwithstanding most extraordinary cold as well as moisture, which the sick there lodged had suffered, remarkably fewer died of the same diseases, though treated with the same medicines and the same general *régime*, than died anywhere else; and all the convalescents recovered much sooner than they did in any of the warmer and closer huts and barns hired round Newport, where fires and apparently better accommodation of every sort could be provided for them."

"Now this striking fact happened to come to the knowledge of Mr. Adair, Inspector of Regimental Infirmaries, who was in the neighbourhood; and he, 'remarking that this currency of fresh air had such amazing salutary effects upon the men huddled in the forest, procured an order to convert Carisbrooke Castle itself, situated upon the extremity of a very high ridge of land, into one large general hospital where near 400 sick might, on occasion, be lodged together.'

"At first," says Dr. Brocklesby, 'it was expected that the sick brought to that place would do better than their comrades who were lodged up and down in the miserable huts of the town, or than those upon the wild bare forest near Newport, under that occasional hovel (meaning the extempore hospital). Yet the event verified our conjectures only in part, for, though the castle was more prosperous to their recovery than the small rooms in low-roofed houses, yet more proportionally of the foresters were recovered, and that much sooner than any of the rest; and it evidently appeared that all the damage and inconvenience

the men suffered from cold or redundant moisture in that place was much fitter to be tolerated, on the whole, than the mischiefs complicated on the sick by huddling together 300 or 400 men and upwards under one roof, and in the out-houses adjoining to the castle.'

"But Dr. Brocklesby has still something to tell us about cheap extemporised hospitals and their good effects, for two years later [1760] a dangerous putrid fever made its appearance amongst the sick of the 30th regiment at Guildford, in Surrey, which led him to erect other hospitals with like good results, and at the reduced cost of something above £10 a piece."

"The sick soldiers were at first taken to their infirmary, about five miles from the camp. As this place was crowded with more than four times the number it ought to have contained, Dr. Brocklesby remonstrated, and obtained from General Cornwallis plenary powers to act. It was in the beginning of September, 1760, when very unusual numbers from the 30th Regiment, and a few from other regiments, were daily falling sick of putrid petechial fevers, and when proper accommodation for the sick could by no means be procured in the town of Guildford, that the doctor made his second experiment. He 'pitched upon the driest and most airy spot,' on a rising ground in the field behind the camp, hollowed out as much of the dry sandy soil as he required, and near the edge of the hollowed ground drove in upright stakes, about 6ft. high from the surface, and placed wattles between them coated on the side next the weather with fresh straw. Rafters were laid over in a workmanlike manner, and coated thick like the sides. This made the hollow 'spacious and airy overhead, and yet abundantly warm and dry.'

"The structure cost the public ten guineas, added to £5 for straw and gratuities to the bricklayers, who built a large chimney and set a kitchen grate. So that probably this hospital for 40 patients did not cost more from first to last than £20. Now Dr. Brocklesby tells us that 'though several soldiers were admitted into this "repository," ill of a true petechial jail fever, only one or two at most died in it; ' and he adds, 'I candidly ascribe their fortunate escape more to the benefit of the pure, keen air they breathed therein every moment than to all the medicines they took every six hours or oftener. For on account of this sandy soil there was an opportunity to remove as oft as necessary the whole inner surface of the floors and walls, which might be suspected to imbibe and retain any infectious matter proceeding from the patients, and the sand so scraped off was, every three or four days, ordered to be thrown out of doors.'"

Another instance of Dr. Brocklesby's experience follows, and then Dr. Mouat continues:—

"I have retained the whole of this lengthened account, because it is of infinite historical interest, and teaches several valuable lessons. There is no need for extravagance in the construction of hospital huts

beyond their being raised sufficiently above the ground on masonry supports, being ventilated throughout at the ridgepole, and each hut being self-contained, with its little kitchen, scullery, nurses' room, water-closet, bath and day room."

"There ought to and need be no difficulty in warming them; and if constructed of properly seasoned and kyanised wood, they would last as long as it would be desirable to let them live."

"In the summer and autumn, nothing is so good and so inexpensive as properly-constructed double-roofed tents, against which an unaccountable prejudice exists, founded solely upon a want of experience of their real value. They are easily warmed, lighted, and rendered proof against weather; can be stored cheaply, and transmitted speedily wherever the need for them may suddenly arise."

Dr. Mouat ends this section of the book with a slight sketch of convalescent homes, a part of the subject that might with enormous advantage be treated of more fully than in this case. We are convinced that more definite information would help to improve the quality of the only partially adapted premises used for this purpose in many quarters.

There are magnificent opportunities for such buildings on some of the high heath-clad parts of Surrey within easy reach of London, with which the situations of most homes connected with Metropolitan establishments will not compare.

Passing from the medical section to that dealing more entirely with the constructive feature of our subject, we find ourselves in the presence of a mass of information put forward in a clear manner by one who has evidently made himself minutely acquainted with the work in its essential details.

We do not find that he has summarised the best features of the buildings herein described, and following the particulars extracted from Dr. Mouat's section, we think the interest of our readers may best be served if we endeavour in the necessarily limited space of this review to point out how far the best examples agree in their various features, reserving for a future notice particulars of their history and description with some illustrations.

Site.—This should slope by choice to the S.E., and should be protected from any drainage from higher ground by deeply-laid pipes.

A dry sub-soil such as sand or chalk is preferable, unless the building can be founded on rock of any kind.

Aspect.—It is desirable that all sick wards should run north and south, thereby securing a better average of sunshine than in any other way.

Drainage.—All drainage should be by means of glazed stoneware pipes cut off by intercepting traps and open gullies from any danger of direct communication with the area of the building. In only one case that we can find in the architectural section is mention made of the advantage of using earth or ash closets, viz., in the report of the evidence given by Dr. Burdon Sanderson before the Commission on Small Pox and Fever Hospitals, published in 1882.

Surely the principle is capable of more extended application in connection with buildings situate in country districts.

Shape and Size of Wards.—Several examples are given of the circular ward system, but preference is shown for a parallelogram which shall contain from 20 to 28 beds, and shall be 24ft. wide by a height of not more than 13 feet. Those who attended the recent Congress on Public Health at Antwerp had an opportunity of carefully inspecting the new General Hospital in that city, which is an example of the circular ward system, and were favourably impressed with it. By way of parenthesis we may add that not only is a separate ward provided for Roman Catholics and for Protestants, but also for Freethinkers !

Warming.—Many methods of warming are described, and one patented by Mr. Snell is shown in detail. This is a stove for the centre of a ward, and for this plan of heating is undoubtedly a good thing. There are, however, so many difficulties as to expense and cleaning attendant upon horizontal flues and the space required for their construction, that we are not prepared to approve the arrangement recommended by Mr. Snell. This is of his invention, and is put forward with some prominence as an independent stove for the centre of a ward. We should have liked to see some description given of Captain Galton's stove for fixing in outer walls. One difficulty with respect to stoves in the centre of wards is that the wall surface, naturally the colder part of the room, is most removed from the heating power, and an even temperature is not attained.

Windows and Ventilation.—Casements for the lower two-thirds of the opening, and a hopper sash to fall inwards for the remainder, all fitted with special fastenings and gear for opening and closing.

We have used double sashes with advantage, air being admitted at the bottom between them by way of constant supply.

Natural ventilation is strongly, and we think rightly,

recommended by inference as opposed to mechanical modes. But in the former category must be included many admirable contrivances for the induction of fresh or the extraction of foul air by causing it in either case to travel along the course of smoke flues.

Several instances (chiefly continental) are given of the ventilation of wards by means of lantern-lights, but the principle does not recommend itself to us without the addition of many precautions against severe down draught.

Artificial Lighting.—As lighting by gas is at present almost a necessity in these large establishments, a mode of conveying away the product of combustion by pipes is recommended.

There is no doubt that, where possible to have it, the electric light (in the incandescent form) is the best, but expense is the difficulty here.

Floors.—Some amount of space is devoted to the description of various forms of flooring. Mr. Snell has used and recommended a simple plan of joists and boarding, the former bearing on each side wall of the ward, and about 12in. deep. This is undoubtedly a cheap form, but we think that a fireproof construction is infinitely to be preferred. All the examples given have wood floors of one form or other, generally waxed or varnished, but an incidental allusion is made to the use of tile floors in China. We are convinced that an arrangement, whereby a floor of good ordinary red tiles may be carried by iron bearers and warmed throughout its under surface by flues or pipes, would largely meet many of the difficulties arising in attempting the equable distribution of heat.

Cement floors are used in some continental buildings, but these we do not approve.

Planning.—We may endeavour to sum up the requirements of asylum or hospital building in this respect as follows :—

All administration offices and rooms to be as central as may be.

All cooking departments to be as detached as possible (without causing difficulty in working them), to avoid the rising of smells to the upper portions of the building.

All wards to be of a size easily worked; to be fairly detached from each other; to have nurse-room, kitchen, and day-room, the latter being of much advantage. The lavatories, bath-room, closets and sinks to be easy of access, but

all air communication to be cut off by cross ventilation in a most careful manner. We highly approve the recommendation to warm the lavatories and closets.

Section 2 concludes with some interesting tables of cost, the result being that its approved examples show an approximate expenditure on the buildings per bed of between £300 and £400, notable exceptions being St. Thomas's Hospital at £777, the Hotel Dieu, in Paris, at £1,215, and the Johns Hopkins at Baltimore at £866.

In our next number we hope to extend what under present circumstances is necessarily a very brief review of a work, which, but for some odd and irritating misprints and mistakes in wording, is a very excellent example of composition, printing, and illustration.

Étude Clinique sur la Grande Hystérie ou Hystero-Épilepsie.

Par Dr. PAUL RICHER. Second Edition. Paris, Delahaye, 1885, pp. 975. (*First Notice.*)

We congratulate Dr. Richer on the splendid book, which represents the second edition of his great work on the disease we know as hystero-epilepsy, but which he, with Professor Charcot, more scientifically calls La Grande Hystérie. To the brilliant originality which characterized the scheme of his original volume, he now adds the perfection of finish, especially in the direction of illustration. But it is not mere pictorial representations, however graphic, which will convince those English neurologists who have not yet been persuaded of the striking accuracy with which the Salpêtrière school have described this most interesting form of neurosis, and so Dr. Richer, although excelling as an artist, piles Pelion upon Ossa in the shape of overwhelmingly weighty scientific facts, that even if any one had not seen a case of the kind, he must give way to such incontrovertible evidence. We say this, however much many may think it a hopeless platitude, because there *are* some who, more in ignorance than in anger, violently contest even the bare existence of such phenomena, and to them we commend the study of the same so eloquently described in Dr. Richer's pages.

We hope to point out at the end of this review the absurd weakness of "le scepticism," "prétendu scientifique" as Professor Charcot calls it, in drawing attention to the extraordinary comprehensiveness and breadth of the position which the observers of this recently discovered or re-dis-

covered disease have consciously or perhaps unconsciously taken up. We conceive that it will not be out of place here to give a short summary of the clinical phenomena exhibited by a patient in an attack of the malady before we pass on to discuss the fascinating connection between them and other instances of cerebral "irritable weakness." We may be forgiven if we just by way of a prefatory title draw renewed attention to the definition of the disease which Messrs. Charcot and Richer offer us. We shall not now enter upon the advisability or unadvisability of retaining the term hystero-epilepsy, but it does seem at this period very advantageous to remind our readers of the great value which is attached to Professor Charcot and Richer's view of the disease as exaggerated hysteria; a view which entails a causative pathology, which we imagine few would object to, namely, that these two conditions (ordinary hysteria and hystero-epilepsy), although differing greatly in degree of violence and in extent of action, *i.e.*, variety and number of the parts of the nervous system involved, yet own a common seat of primary excitation, and therefore pathologically are closely united. Such an argument is very little, of course, when taken by itself, but it stands firmly on the clinical evidence afforded by every stage existing to show the gradual passage of the one condition into the other.

We cannot do better in giving an epitome of Dr. Richer's description of a complete attack than by re-producing the stages into which he groups the phenomena, it being clearly understood, as he himself urges, that such grouping is merely adopted for ease of description:—

1st stage: Prodromata.

2nd stage: Epileptoid period, including phases of tonic and clonic contraction and "resolution."

3rd stage. Period of contortions and violent movements, which he designates "clownism."

4th stage: Period of emotional and passionate attitudes.

5th stage: Period of delirium and hallucinations.

The patients who are the subjects of these attacks are doubtless infinitely more common in France than in England. It would be very interesting indeed if we could find that it occurred commonly in the Welsh and Irish branches of the Celtic family, but whatever race they belong to they seem to present very much the same prominent characteristics, and owe their misfortune almost always to a similar causation, namely, severe fright as a leading factor, coupled with aber-

rant sexual function. Usually they are young or middle-aged women, very rarely men, capable of performing many social duties, but rendered prostrate at times of varying frequency by the epileptoid attacks and their sequelae. Such persons, moreover, present several well marked neurotic phenomena, which have especially been the object of ridicule by the sceptics so gently denounced in the preface by Professor Charcot. These symptoms are hemianæsthesia, spots of excessive hyperæsthesia, etc., etc., and depending as they apparently do on functional disturbance of the sensory portions of the cerebral hemispheres, are influenced by means which appear absurd to those who have not studied the subject in its innumerable relations with other well ascertained facts of hypnotism, &c., &c. Following Richer's description closely, we commence, then, with the mental prodromata. Naturally these affect the emotional side of the patient's nature *par excellence*, and commence, it is to be understood, not merely on the day of the epileptoid attack, but may precede it by at least a week. Under these latter circumstances the patient finds it impossible to fulfil social obligations, not being able to confine her attention to work, or remember facts of immediate importance. Such a patient is often deeply melancholic, or on the other hand restless, jealous, and irritable. The irritable stage may be accompanied by cries, just in the same way as the stage of delirium often is. We will now turn to the prodromatous symptoms, which are apparently the result of excitations of the medulla oblongata, and will commence with the disturbance of the respiratory centre as the most important. Every one is familiar with the sense of suffocation, which forms so marked a feature of ordinary hysteria, and it is never wanting in the graver attacks as an introduction to the complete process, and accompanying it are minor symptoms, such, for example, as loss of voice, laryngeal spasm, and continual yawning.

Passing to the cardiac and vaso-motor centres, we find that the heart palpitates violently, the pulsation in the arteries being vigorously marked in the neck and the temples. Vaso-motor troubles are rare as a rule, but have been observed to resemble the vaso-motor disturbances seen at the climacteric, viz., dilatations of the vessels evidenced by flushings and heat of the surface. The contrary, viz., cold and cyanosis, are sometimes noticed.

Visceral changes, *e.g.*, gastric crises, large collections of

gas in the large intestine, borborygmi, etc., frequently occur. In this prodromatous stage, tremors are noticed just as the patient is dropping off to sleep, and usually occur just before the onset of the epileptoid fit. Rigidity of limbs (contracture) is also frequently present, is very interesting in connection with the question of the seat of the lesion, and will be noticed later on. Hemianæsthesia has popularly gained the reputation of being the symptom *par excellence* of hystero-epilepsy, and is certainly of very general occurrence. Here we will note that the anæsthesia is rarely complete while analgesia is the rule. The patient cannot feel any pain from a prick, but is conscious of being touched by the pin. Hyperæsthesia, sometimes also present, is usually limited to little patches here and there, the so-called hystero-genic zones, or more accurately speaking, areas. Total blindness usually accompanies complete hemianæsthesia, and is on the same side.

The next point connected with prodromata is the existence of an aura. The commonest form it takes is acute ovarian pain, and many patients complain of general pains, especially about the neck, of the *globus hystericus*, and of sudden shocks and sensations of fulness in the stomach. Professor Charcot demonstrated years ago that the seat of onset or of the origination of the disturbance was a painful ovary. Since that discovery several spots about the trunk and more rarely about the limbs (Pitres) have been found to similarly afford a starting point for the stimulus to the spinal cord when they are pressed upon. Such points are:—(1.) Over the ovary; (2.) Superior iliac spine; (3.) Tip of the eighth rib; (4.) Under surface of breast; (5.) On the breast; (6.) On the first and tenth dorsal spines of the vertebræ. Just to the side of the latter point is sometimes another. All these points are painful to pressure, and on the same being applied they cause the excitation of the fit or the arrest of it when it has begun. The latter facts will perhaps explain the occurrence of what has been long called hysterical spine. In dismissing this part of the subject—and, being a minor point, we shall not return to it again—it seems possible to us that the hystero-genic areas are situated simply on those parts of the skin which are directly connected by nerve fibres with that portion of the spinal cord which happens to regulate the functions of the breast and the genital organs, and consequently pressure stimulates the portion of the cord which is connected functionally with the organs just men-

tioned, and that this stimulus passes up to the highest centres.

We now come to the second stage, which has the greatest interest for us personally, and which Dr. Richer has handled in so masterly a way as to make it almost impossible for us to give up the term hystero-epilepsy. As we wish to specially examine this point later, we shall content ourselves with only a few remarks now respecting the details of the epileptoid convulsions, just noting the peculiarities which separate them on the one hand, and connect them on the other with true epilepsy. The first exception we would draw attention to is the absence of any cry. Occasionally, however, as might have been expected from the fact of laryngeal spasm occurring, guttural noises take the place of the characteristic epileptic cry. Loss of consciousness, of course the most important feature of this stage, is invariably absolute; and here again we have another point of deepest interest in determining the seat of this grave functional disturbance. The stages through which the patient passes are exactly those of ordinary epilepsy, namely, the tonic, the clonic, and the phase of resolution with stertor. The tonic phase is usually an imperfect tetanus; the clonic consists, of course, of quickly succeeding sharp contractions of the muscles, these contractions being almost always four per second in the very valuable tracings with which Dr. Richer has fortunately illustrated this branch of the subject. The pupil in the tonic stage is contracted, in the clonic dilated. We should like very much to have described this stage at full length, but really we should only be wearying our readers with an account of an ordinary epileptic fit, and moreover we intend to refer to this point again.

Concerning the stage of relaxation ("resolution"), we only wish to remark the occasional occurrence of single sharp contractions of the muscles, we having ourselves observed this phenomenon after the artificial induction of epilepsy in the lower animals.

Following on the stage of "resolution" we have a brief period of violent movement in which the whole body is thrown into extraordinary contortions, an exceedingly constant figure of which is the so-called *arc de cercle*, which is practically nothing but ordinary *opisthotonus*. Dr. Richer tells us he has given "*le nom pittoresque de clownisme*" to this stage.

The last two stages as Dr. Richer gives them to us are

really but varying degrees of the same mental state. His expression for the former of these is "la période des attitudes passionnelles," and the latter "période de délire." But the mental undercurrent of this stage is exactly the same, namely, hallucination. Thus in the first the patient clearly imagines very distinctly that she sees persons of whom she is very fond, and addresses them in appropriate terms, while in the second the tone of these terms is changed to hatred and rage, and finally the hallucination resolves itself into zoopsia, the patient imagining that she is surrounded by animals.

Let us here remark that although the subsequent periods are of very variable duration, the actual epileptoid seizure does not usually last more than two minutes, this interval of time being a matter of especial interest in considering the pathology of this affection.

Suicide: Its History, Literature, Jurisprudence, Causation, and Prevention. By W. WYNN WESTCOTT, M.B.Lond., Deputy Coroner for Central Middlesex. H. K. Lewis, Gower Street, London, 1885.

In a former number of the Journal * we gave some important statistics of suicide in England and Wales, based on the returns of the Registrar-General. We avail ourselves of the book whose title heads this review to return to the subject, and to give additional statistics relative to suicide in other countries.

The author discusses the ethics of suicide, and gives a brief history of ancient and modern opinion in regard to it, illustrated by a considerable number of examples from the time of Sesostris to the unfortunate medical student Mahomed Ismail Khan, who destroyed himself in London, in 1883, by prussic acid. The literature of suicide is rapidly sketched, and a useful bibliographical index is appended. The chapters on the criminal and civil jurisprudence of suicide will be found useful, and form a curious comment on the variety of opinion in different countries, and in different times in regard to *felo-de-se*. Mr. Westcott considers that the true doctrine of English law in regard to suicide may be stated thus, in its relation to insanity:—"If suicide affords any presumption of insanity, it is of insanity at the moment

* July, 1885.

only, and even then, it is not enough to deprive the person of imputability. *Felo-de-se* is a crime, and a person is innocent until found guilty." We fully concur in the opinion that if there is no other indication of insanity than self-murder, the evidence is insufficient. In short, suicide may be committed by a perfectly sane person. In the United States, suicide is not and never has been regarded in the light of a crime against statute law, and yet any one accessory to a suicide is regarded as guilty of murder. The French law is stated to be as follows:—"The law has not incriminated the suicide. Is the fact of complicity punishable? Evidently not." In civil law, the question of the nature of the act becomes of great importance in relation to policies of life insurance. The custom of inserting the proviso that suicide shall render the policy void has become practically null by the universal course pursued by coroners' inquests in finding a verdict of "temporary insanity," and therefore unaccountability. In 1845 the judges decided, in a disputed case, that the term suicide used in the policy signified "intentionally killing himself," whether in an insane state of mind or not. The assurance companies consequently altered the wording of their policies, some inserting clauses allowing the compromise of such claims, others distinctly stating that any voluntary death should render a policy void. Equity, however, has induced almost all companies to pay the insurance. Mr. Westcott states that, with few exceptions, companies are agreed in making policies indisputable.

In regard to frequency, the civilised states of Europe (with three exceptions) indicate a uniform increase of suicides, making due allowance for increase of population. A table is given showing the difference in the rates of variation per cent. between population and suicide from 1865 to 1876. The increase of suicides per cent. on the total number is for England 27.1, in Belgium it is as high as 64.4, and in Switzerland the increase is nearly as great. The variation in the population between 1865 and 1876 amounts to 14.6 in England, 7 in Belgium, and 6.5 in Switzerland. The annual number of suicides per million of inhabitants in different European States is as follows:—England, 74; Scotland, 48; Ireland, 24; France, 216; Belgium, 90; Spain, 19; Russia, 35; Italy, 44; Holland, 51; Austria, 144; Switzerland, 240; Denmark, 265; and Saxony, 469. It is difficult at first sight to believe that these returns are sufficiently accurate to allow of our making safe comparisons and inferences, but

it seems probable that there is actually a larger amount of suicide in the central and upper two-thirds of the North Temperate Zone than in the countries of the West and the South of Europe. "In Europe the highest proportion of suicides is shown by the Germanic races, and the two stocks, Germanic and Scandinavian, divide the supremacy for the maximum rate" (p. 77). Again: "In Norway the rate was for very long also extreme, but the great severity of recent laws in respect to offences and to drunkenness has made an almost incredible reduction in the amount of suicide" (*loc. cit.*). It would seem that the Celtic races are little prone to it.

In regard to the influence of the various forms of religion, statistics, such as they are (and this qualification is justified by the remark of Brierre de Boismont, that in Paris the actual suicides are almost double the number registered), show a maximum rate in Protestant States, and a smaller one in the Roman Catholic and Greek Churches, while the minimum is found among the Jews. The author thinks that the proportion of suicides allotted to Protestants is much too high, and observes that, "curiously enough, Catholics far exceed Protestants in the statistics of total crime in all countries" (p. 85).

In regard to age, it is stated that the proportion of suicides increases from childhood up to 55, and then uniformly declines. This observation applies to the greater part of Europe. In regard to England, however, the suicidal tendency increases with the advance of age to the next decennial period, and then diminishes. In this Journal for July, 1885, the suicides to a million persons living at different ages in England and Wales, 1861-1883, were given as follows: From 15 to 20 years of age, 28; from 20 to 25 years, 47; from 25 to 35, 68; from 35 to 45, 113; from 45 to 55, 175; from 55 to 65, 237; from 65 to 75, 230; from 75 and upwards, 170.

As regards sex, Mr. Westcott finds that three males to one female is the prevailing rate shown by the majority of States of Europe, while, as regards England, the calculation of the Registrar-General in 1880 is quoted to the effect that the chance of a male infant dying by suicide is 1 to 211, and of a female 1 to 578. The present proportions of some other European countries are given thus: France, 79 male to 21 female suicides; Italy, 80 to 20; Prussia, 82 to 18; Spain, 71 to 29; Saxony, 77 to 23; Russia, 80 to 20; Holland, 78 to 22; Ireland, 78 to 22; and Scotland, 72 to 28. It may

be added that in the United States of America the proportions are given as 79·25 to 20·75 (p. 108-9). We stated in the article already referred to that in England and Wales 22,954 men committed suicide from 1861 to 1883, while only 8,022 women did so, and that, calculated on a million persons living in 1883, the ratio of male to female suicides was as 111 to 38, or, during the whole period of 1861-83, as 105 to 35, and we summarised the liability of the sexes to suicide in our country thus:—Among equal numbers living of both sexes there were exactly three male suicides to one female during 1861-83.

We here take leave of Mr. Westcott, and can recommend his book to those who desire to study the subject of suicide in its various relations in a succinct and methodical form.

On Psychical Analysis as the basis of Morbid Psychological Diagnosis. By Dr. J. N. RAMAER, Inspector of Asylums in Holland.

Dr. Ramaer holds, and justly, a very high position in Holland, and we are glad to have any of his views in print.

Few will be inclined to dispute the truth contained in the above heading, or fail to see that a study of mental science and a knowledge of the fundamental facts of normal psychology must precede the study of morbid psychology. The analysis of mental states is, however, admittedly most complex, and demands consideration at length, if the subject is to be set forth clearly. The author of the above brochure is of course aware of this, but we think he has nevertheless undertaken too much for the space at his command.

He starts with the fundamental fact of *consciousness*, but at the outset insists that this must be carefully distinguished from the consciousness of self (*Selbstbewusstsein*), the Ego, a distinction which some philosophers have failed to observe. Consciousness, he urges, is a fact not capable of further analysis, but the Ego, so he says, is not thus simple, but comprises "the sum of the psychical effects which have been brought into consciousness." Can this distinction be maintained? Let us grant that self, the Ego, is complex and includes, ex. gr., the consciousness of my arm and my leg and my foot, and a multitude of other consciousnesses of bodily parts, still we must note the one constant element "my" in all these consciousnesses. Remove this element,

dispossess consciousness of all selfishness, and reduce it to consciousness of leg, and arm, and foot, and what does it mean? To us it appears that the element "self" is a fundamental fact in consciousness and itself not capable of further analysis. It must be clearly understood when this statement is made, that the self thus contended for is not the self which is made up of hands and feet of a certain shape, muscles of a certain strength, etc., but that self which has hands and feet and muscles, no matter their size or shape or strength. But we must proceed. The next step the author takes is to create an organ of consciousness, which he defines as "that portion of the body whose vital activity manifests itself as consciousness." This organ Dr. Ramaer places in the grey matter of the floor of the fourth ventricle beneath the median groove. The arguments for choosing this spot are ingenious, but unfortunately the organ itself thus located is purely hypothetical, and to us the hypothesis of such an organ or centre is unwarranted. Is it not simpler to regard the several groupings and combinations of nerve cells which constitute our higher nerve centres as each of them an organ of consciousness in the sense in which the author defines this organ? It is true that in each such organ the kind of consciousness will be a different one—this difference resulting from the difference in structure obtaining between one centre and another—but modes of consciousness we must admit, and according to such view we shall find less complication than if we create a special organ for consciousness, which organ we shall of course have to put in structural connection with all parts of the nervous system.

Dr. Ramaer then discusses the "Functions of Consciousness," sensation, pleasure and pain, also inhibition, but they are dealt with very cursorily, and the like is true of the subject—the presentation of ideas. The next section deals with the association of ideas—trains of thought—and also with the question of what may be termed unconscious thought, though the terms seem to imply a contradiction. Lastly, the will is just mentioned in a few lines.

The last section treats of the application of the foregoing analysis to the psychoses, but this part is very sketchily thrown in. This sketchy treatment is indeed an objection which will be made to the whole essay. In the space of eighteen pages, is it indeed possible to deal satisfactorily with such abstruse questions? A mind full of its own subject, and familiar with its many sides and intricacies, does

not always estimate at their true value the difficulties of those less initiated. This we think has been the case with Dr. Ramaer, and hence, some—though knowing nothing better, indeed far less—will not be able to follow the injunction, “his utere mecum.”

The Asclepiad. July, 1884, to October, 1885.

Dr. Richardson continues to supply the readers of his journal with articles of great interest and ability. The series of biographical notices of celebrated physicians is a valuable contribution to medical literature. The notice of Dr. Gilbert, “the first electrician,” contains matter probably new to many. He was the author of “*De Magnete*,” published in 1600, which appears to have formed the basis of all subsequent electrical science. In the same year he was President of the Royal College of Physicians. A portrait and a view of the house in Colchester in which he was born are given. He practised physic for more than 30 years in London, and was Court Physician to Queen Elizabeth and James the First.

The sketch of Dr. Rush is excellent, and exhibits this remarkable man’s manifold interests and sympathies. He objected to capital punishment, and wrote: “Let it not be supposed that I wish to palliate the enormity of murder. Far from it. It is only because I view murder with such superlative horror that I wish to deprive our laws of the power of perpetrating and encouraging it.” He objected also to judicial oaths because, among other reasons, they produce in the mind an idea that there are two kinds of truth, one for common and the other for solemn occasions. He advocated the higher education of women. He was strong in his opposition to slavery; indeed, the first spark of the fire of sympathy for slaves was kindled, it appears, by Dr. Rush. He proposed what Dr. Richardson regards as his greatest idea, a Secretary of State for Peace, whose great function would be “to subdue that passion for war which education, added to human depravity, has made universal by familiarity with the instruments of death and by military shows.” Again, he was a man after Dr. Richardson’s own heart in denouncing the evils of intemperance and the necessity of abstinence. Nor was he the less the enemy of tobacco smoking and snuff taking. “He calculated that a

confirmed snuffer lost five days' time out of every year in the mere act of lifting the snuff from his box and drawing it into his nose." His opinions and practice in mental disorders, especially in regard to blood-letting, have been described elsewhere.*

"The Asclepiad" for April, 1885, contains an interesting notice of the celebrated Vesalius, born in 1514, in Brussels. In him, observes Dr. Richardson, "industry, courage, and skill in exposition were the living attributes which gave him power in his own time, and enduring power after his time. His mind, the purest analytical, was fitted strangely to unravel and expose natural secrets, but was poor in constructive or synthetic quality, and, therefore, weak in discovery of the natural principles or designs relating to the parts of natural objects; the mind of an anatomist as distinguished from a physiologist, the logos left out altogether. Intense, proud, and perhaps avaricious both of fame and wealth, he was borne on, nevertheless, by a magnificent impulse towards, and to, as magnificent a fame as ever befel a soul of science of any age or race." In subsequent numbers Dr. Richardson gives biographies of Boerhaave and Leeuwenhoek which well repay perusal, and are accompanied by striking portraits. The former refers in his Aphorisms to melancholia and mania. The cause of melancholy, defined by him to be *ille morbus, in quo aeger delirat diu et pertinaciter, sine febre, eidem fere et uni cogitationi semper affixus*, was, according to him, in common with most physicians, black bile, while mania he regarded as only a higher grade of melancholy (*si melancholia eo usque increscit, ut tanta accedat agitatio liquidi cerebrosi, qua in furorem agantur saevum, mania vocatur*.) Ducking in water he prescribed as the best treatment.† (*Præcipitatio in mare, submersio, in eo continuata, quamdiu ferri potest, princeps remedium est*. Aph. 1123). The latter, although not educated as a physician, was a remarkable anatomist. It has been hitherto supposed that he was an optician, but Mr. Wynter Blyth has made out that he filled the office of Beadle or Chamberlain of the Sheriff at Delft, at a salary of £26 a year. "Who would think," writes Dr. Richardson, "that one who was deputed to open and shut the door of the Council Chamber, and show honour and respect to the councillors of the little town of

* "The Insane in the United States and Canada," by Dr. D. H. Tuke, 1885.

† Versuch einer Literärgeschichte der Pathologie und Therapie der psychischen Krankheiten. Von Dr. J. B. Friedreich, 1830.

Delft, would, in after days, have such a name that learned men of other nations should make it a point of scholarship to find out what he did for a living." To Leeuwenhoek are due the first attempts to determine the structure of the brain and of the nerves. "He distinguished carefully the particular character of the grey matter, and supposed that its darker or grey colour was caused by the greater number of blood-vessels which pass into it; while, with equal care, he explained the fibrous structure of the white matter."

These biographies may seem somewhat removed from the range of subjects covered by this Journal, but a little consideration will show that all these men contributed to the knowledge which it is necessary the psychological physician should possess, for he is indebted, however indirectly, to the "first electrician," Gilbert, to Vesalius for the "birth of anatomy," to Boerhaave for "the origin of scientific medicine," to "the founder of histology," Leeuwenhoek, and above all to Dr. Rush as the father of medical psychology in the United States. Dr. Richardson will, no doubt, continue this series of biographies, which, when completed, will form a valuable collection of medical biographies.

Recherches experimentales sur le mécanisme de fonctionnement des centres psycho-moteur du cerveau. Par Dr. J. M. L. MARIQUE. (*Thèse d'agrégation présentée à la Faculté de Médecine de Bruxelles.*) Bruxelles et Paris, 1885; pp. 136.

It has given us the greatest pleasure to read this extremely interesting and philosophical monograph, which relates, as few do, to the intimate connections of the excitomotor area of the cortex with the sensory centres, or at any rate with the afferent paths in the brain. By way of preface, Dr. Marique provides us with a very succinct account of the researches that have been carried on in this direction since 1870, and, further than this, has contrived so to connect and summarize the often apparently conflicting facts brought forward by different observers as to present us with a pleasant, and withal accurate, account of the present state of our knowledge on this subject. We mention this historical summary here in these terms because it is certainly one of the best we have ever read, and because we have no further space to dwell upon the scientific acumen with which the author has criticised several researches which have in-

comprehensibly influenced the physiological and psychological views of too many.

Having thus discharged what we conceive to be a gratifying duty, we now wish to draw attention to the second part of Dr. Marique's thesis, namely, the very novel mode of experimentation by which he seeks to investigate the physiology of the so-called motor centres. Briefly he has attempted to isolate the motor centres (or the limbs) in the dog from the surrounding cortex without interfering with the efferent motor fibres leading down from these centres to the muscles, and forming the well-known direct pyramidal tract. It will be remembered that the motor centre for the head and neck and limbs in the dog are mainly aggregated in the sigmoid convolution which surrounds the crucial sulcus, and it will be remembered, too, since the crucial sulcus is homologous with the fissure of Rolando in the higher animals, that the anterior and posterior portions of the sigmoid gyrus may justly be regarded as the ascending frontal and ascending parietal convolution respectively. Now, the fibres which connect one convolution with another, "arcuate fibres," and the fibres which connect the motor centres with the sensory perceptive area are grouped together by Dr. Marique under the general heading of "association fibres." We must confess that according to our notions Dr. Marique's view of the arrangement of these "association fibres" is rather simpler than present anatomical knowledge warrants, but in justice to him it must be remarked that his work is only concerned with the terminations of these fibres in the motor area. The simplicity of his experiment cannot be too highly commended, even if the results which he has obtained are not more than might have been expected from ordinary *à priori* reasoning. His experiment consists in carrying a vertical incision round the sigmoid gyrus to the depth of seven to eight millimetres. Apparently this is done with very little damage to the main vessels of the pia-mater, and, of course, no injury to the pyramidal tract. Let us note in passing what appears to us to be a very serious defect in his operative technique, namely, the absence of antiseptic treatment of the wound; indeed, it seems to us quite clear that many of the animals died of septic meningitis. Further, although we are loth to seem hypercritical, still we must confess that the absence of details concerning the condition of sensibility in the parts paralysed is to our mind a grave omission. In saying this we are not, of course, guided by the extraordinary views of

Schiff and other writers, but we simply feel, and especially in a research of this kind, that a great deal of dispute about the functions of the excito-motor area of the cortex has arisen in consequence of the popular ideas concerning the spontaneity and independence of voluntary actions. The net result of his experiments amounts to this: that section of the "association fibres" produces almost the same effect as destruction of the sigmoid gyrus itself or of the pyramidal tract leading from it. In other words, the "motor" centres have no function in the absence of sensation, an experimental illustration of Dr. Hughlings Jackson's "First Principles." We hope that this new demonstration of the physiological truth of localization of cerebral function will receive at the hands of neurologists the attention it deserves.

Insanity. Modern Views as to its Nature and Treatment.

By W. T. GAIRDNER, M.D., LL.D., Professor of Medicine in the University of Glasgow, &c., 1885.

Professor Gairdner makes the study of insanity a conspicuous part of general medicine. Of this he has given proofs on several occasions; his most recent utterances being published under the title at the head of this notice. The basis of his pamphlet is laid in the Morisonian lecture which he delivered in Edinburgh in 1879. This lecture was reproduced in an address delivered before the Glasgow University Medico-Chirurgical Society at the close of the Winter Session 1884-1885. In it he strongly advocated the necessity for more attention being paid to insanity in the medical curriculum, and pointed out "that recent instances showed that public opinion would not much longer tolerate a state of the law and practice in dealing with the insane in which the most delicate and important questions arising as to the insane mind might be submitted to persons medically educated, but in reality wholly devoid of experience or even of systematic instruction in this department of the healing art." The author states, however, that the object of the address, and of the whole series of the Morison lectures, of which it forms a part, was to show "that the principles underlying the modern treatment of the insane are precisely the same as those which have been emerging into more and more prominence in connection with what are admittedly bodily diseases." An appendix of notes is given which extends to

a greater length than the address itself. The subjects treated of in these notes are—"On the Early Training and Mental History of John Stuart Mill, considered in reference to some peculiarities in his writings; the Subjection of Women, by the same writer; Christianity, Witchcraft, and Demoniactal Possession; Genius and Insanity; and lastly the Wyndham Case." Dr. Gairdner always brings a charming freshness to whatever subject he discusses, and an impartiality which carries the reader along with him. We regret that our space will not allow of our making more extracts, and must content ourselves with referring the reader to the pamphlet itself.

Physical Expression. By FRANCIS WARNER, M.D. Vol. 52 of "The International Science Series."

La Physionomie et les Sentiments. Par P. MANTEGAZZA. Vol. 49, "Bibliothèque Scientifique Internationale."

Though placed together for the purposes of review, these two books are at the opposite poles from the reader's point of view. The first is decidedly hard reading, brimful of facts and careful methodical treatment, whereas the latter, though full of observations and of points of interest, is so pleasantly put that we read as we run.

It must not be considered from this that we object to Dr. Warner's style or method, but we suffer from the weight of the subject.

We shall begin by considering "Physical Expression." It is difficult to review fairly a book which has few or no compeers. If the book had been upon the hand and its expression, or on the face and the relations of its movements to feelings and to character, we could have compared it with others; but when the whole subject of expression is considered, when every outward sign of every inward action is attempted to be arranged for future study, we feel the enormous extent of the land which has to be surveyed, and begin the study of the book with a good deal of nervousness. In reviewing a book of this kind, as in fact in reviewing any book fairly, the first thing is to consider what the object of the author is, and next whether he has done what he intended. The questions of the worth of the original object and the manner of the execution of the self-imposed duty may be then considered.

The book is addressed to all students of the living and

thinking man, and is intended to supply some means of measuring mental changes by simple physical means which are used for the measuring of the expression of nervous states and conditions.

In the first chapter are laid down the lines on which the author intends to work, and it is interesting to find that he obtained but poor results from observations of the size, shape, and proportions of the head, and was driven to observe the motor functions and their brain relations. The studies in this book are undertaken to form a stepping-stone for higher observations on mind, and we agree with the author in saying: "The method of procedure appears to me more likely to lead to practical results than any subjective process of introspection of the feelings."

We are glad, indeed, to see a general change in the opinion of thinkers now-a-days. Time was when no one considered that philosophy could be advanced in any way better than by self-analysis, and comparison of the result with the analysis pursued by others. This subjective process naturally led to the very careful definition of the various mental states and an elaboration of forms which required as much practice to use as the acquirement of a new science or language. But only some people are fitted for this process, and the consequence has been that similarly constituted men having gone in for self-analysis, a very small part of the whole field of mental action has been studied.

Herbert Spencer has had a very great influence in England in making men more objective in these researches, and both Drs. Warner and Hughlings Jackson may be looked upon as disciples of Spencer, who have fitted his method of work to observations in diseased, and in developing, nervous function.

Though it is well to vary the methods in mental philosophy, we do not think that success of the best kind will result from the purely objective or the purely subjective methods. The philosophy of the future must be begun from such exact observations on the initial mental powers of animals and infants, as those of Dr. Warner must be developed further from similarly exact observations on the imperfectly developed and the degenerating, and also from the comparison of many observations during healthy performance of functions. The recording cylinder, the photographs of Marey, and electrical registers and measures of action and re-action, will all contribute to founding a base on which a more permanent

philosophy can be built; then we believe subjective states may usefully be made use of, and disordered states such as seen in delirium and in madness. The late Dr. Carpenter said to the reviewer, only last autumn, that if he had to begin life again he would devote some years to asylums, before he wrote another book on "Mental Physiology."

Dr. Warner does not attempt to plunge beneath the surface to decide what is mind or what is life; it suffices for him that these evidence themselves by movements which can be measured and recorded, and he successfully registers his results. He promises to enlarge his field of work, or rather to continue his work, and every one must wish him well in his painstaking labour, though we feel ourselves that he has a very long life's work to do to fulfil his promise. The chief object of this book is said to be "observation of the ingoings and outcomings" of the body, not the mere machine at rest. The first five chapters explain the scope of the work. In Chapter VI., certain physiological facts of plants and animals are considered; and in VII. the physician will find many interesting records of pathological nervous states; in fact, this chapter is rather too medical for a lay reader. In Chapters VIII. and IX. postures are considered in detail, and the chapter containing reference to the hand is very interesting, Dr. Warner having very carefully observed the hand in many persons, in many varying conditions.

He very carefully distinguishes between strong and weak hands; there are cuts of the convulsive hand, the hand in fright, the feeble hand, the hand in rest, besides drawings of certain forms and positions of hands which he considers to be of importance.

We do not agree with all that is said about the hand, but this may be due to our want of careful attention to details of position. It is common to see hands belonging to different forms on the right and the left side respectively. Thus a man of the professional classes in England, who has spent a fair part of his time in athletic pursuits, may have an energetic right hand and a nervous or artistic left hand. When, some time ago, the nearly related subject of body measurement was considered, it was found that, though from an artistic point of view the index finger should be longer than the ring finger, yet really in hard working or vigorous men this was often true of the left hand, but not of the right.

In analysing any posture of the hand Dr. Warner uses

certain principles; he considers the relative position of each joint in each posture. The large and small joints are to be looked at separately; thus in chorea the movements of small joints are most obvious, and, as he says, a slight amount of brain disease will interfere more with the use of the fingers than with the use of the arm; the symmetrical affection points to general, not unilateral nerve changes. The state of limbs in sleep or during rest is noteworthy, and thus he has elaborated a process for investigating and recording postures and movements in health and disease.

It may seem that, having examined thus carefully the constituents of posture, he would have also considered the relation of the hand-posture to diseased states generally, but this is, doubtless, left for his more elaborate book.

We fail to notice any allusion to the hand-genital posture so common in brain disease, and so rare in ordinary fever. Addison and Wilks have both taught the importance of noticing the restlessness of the brain alone, and the tendency to resist and to lie with the hand over the genitalia, while in fever the supine patient lies with hands by his side and does not resist.

In Chapter X. expression of the head is considered, and here we see a good example of the method of the book. The head as a whole is considered, and then its movements; the full consideration of physiognomy is omitted—wisely, we think—for it has been already done so often and so well that one dreads another treatise on the subject.

Among movements of the head we have flexion and extension, rotation and inclination, and everywhere the mechanical and the anatomical explanations of the movements are given. Under “rotation” we come across a passage which leaves us in doubt as to its import; rotation is explained to be the expression of negation, just as flexion and extension express acquiescence. “Now sometimes we find a child so irritable that the prominent master (brain) condition is such as to be all negation; the head rotates at all propositions,” &c. If the converse were to hold good there ought to be a drill for the flexion and extension of children’s heads so as to get them thereby into a state of acquiescence.

Besides the consideration of the head as a whole, the jaw as a part is also studied, and the question of elongation of face due to dropping of the jaw is mentioned.

Dr. Shuttleworth is quoted in reference to head defects in idiots. The short chapter on expression in the human face

is, as we have already said, meagre; and we think various features have reason to complain, the eyes being credited with little power in themselves, depending chiefly on their lids and surroundings. Dr. Warner gives his easy method for examining the different parts of the face by covering one part with a sheet of paper while the other is uncovered.

He is certainly right in considering the upper part of the face as expressive of the higher intellectual powers, and the lower as related to the more organic; as Dr. Sutton has said, the lower part of the face has muscles involved in the same processes as the abdominal viscera, and so expresses a relationship with them.

One subject of growing interest and importance which has for a long time attracted Dr. Warner to its investigation is the expression of the dawning mind in the infant, and the physical evidences of the growth and development of mind. This subject is carefully studied in Chapter XIV. And the tracings of the spontaneous movements of the infant's hand are suggestive and original.

It is very interesting to be able thus to get expressions of mental action long before mimicry or speech can disclose what is passing, and the further development of this subject will be anxiously looked for. Dr. Warner has investigated the spontaneous healthy muscular movements, and also morbid movements as seen in athetosis and chorea, and two most interesting chapters are occupied on medical studies of expression of pathological states chiefly in children.

The chapter which will appeal to the largest number is that on art criticism, and though there is nothing very novel in the suggestions, and but little new in the instances and applications, the chapter will be read with interest. We feel the dependence of art upon truth, but just as we have a prejudice against the artist who shows us his anatomical knowledge, so we fear we shall not like the work of the artist who is thinking of the machine in action. In discussing art the hand and the face are the chief parts studied, and reference is made to some of the best known sculptures and frescoes.

The volume contains a reference to authorities which appears sufficiently full for reference to the matter in hand, but leaves out many books on special parts of expression, but this was a natural and designed omission.

The last chapter contains a description of the instruments used by Dr. Warner in his experiments, and are very simple

and ingenious. M. Marey has for years been working at instruments for recording movements, and our author has taken many hints from him. Electricity and photography have a great future in thus fixing the most transient movements, and enabling comparison of allied and co-incident states.

This review must conclude with an expression of good wishes to the author, and desire that he may be able to further develop his work.

With this development, the bare bones of fact would then be clothed with a greater grace and more attractive manner than is compatible with brevity and exactness.

The second book, that on "Physiognomy," by Mantegazza, is one which we should recommend every one to read; not only because it is full of knowledge, but because its style is so refreshing. It is a book which could only have been written by a member of a Latin race.

The translation into French seems to be remarkably well done, so that the force of the author is not lost or spoiled.

The volume is handy and well-printed, and contains eight pages of illustrations after original drawings by Hector Ximènes; and these illustrations are characteristic, and have a freshness for those who have seen Lavater reproduced till they are tired of the same sermon from the same text. Personally, we cannot think the author has been particularly happy in the letter-press to the drawings, many of the aspects suggesting other ideas than those intended.

It seems to us that, after all, this studying of physiognomy apart from the rest of the body is a mistake; it is like the artificial classification of flowers, which was convenient as a starting point, but had to be given up when wider views of the vegetable kingdom were obtained.

That there are some fundamental aspects we admit; but when irony, cynicism, modesty, adoration, pride, and ferocity are represented as different, and are described anatomically, we are obliged to be doubtful of the author's scientific method.

But the whole book must be taken to mark a very distinct epoch in the study of expression, for it not only sums up the classical writings on the subject, but considers and discusses modern scientific teaching, such as that of Darwin, in its relationship to the development of expression in man. Any attempt to give a *précis* of the book would take too much space, and might lessen the pleasure of the reader.

The author says the book is a page in Psychology, a study of the human face and human expression. It takes up the study of Expression where Darwin left it, and, perhaps, makes a step in advance. We have a careful historical chapter which treats of the various stages of development through which physiognomy has passed, reference being made to Aristotle and Plato. This latter saw striking physical resemblances between men and animals, and inferred that they had similar mental attributes. This assumed resemblance takes for granted that we know a good deal about the mental characteristics of animals; and Plato considered that a leonine man would be generous and bold, but considerable doubts have been thrown upon the virtues of the lion; and our late associate, Dr. L. Lindsay, did not believe in the nobility of that animal.

The comic prints of all time seem to have been struck by the resemblance of men to animals; and many recent numbers of "Punch" have struck out rather unexpected likenesses between our statesmen and the brutes. We have examined the book by Dalla Porta, published in 1627, and have found very many drawings comparing men and animals which would have been perfectly suitable for "Punch" of to-day.

With our author, we think this process of comparison may easily be carried too far, and that Darwin would have been the last to allow such superficial likeness to mislead him, and take away his attention from more obscure, but more real resemblances.

A summary of the students of chiromancy is given, but as this has fallen much out of fashion, we shall leave all discussion of it. This, like many other subjects, has, says our author, many authors, many volumes, little originality, and much plagiarism.

We believe there are still followers of chiromancy among us, for recently we saw an advertisement about the subject in a pseudo-medical journal.

The subject of physiognomy would be imperfectly introduced if Lavater and Charles Bell were not referred to, and instances are given in which, from the examination of the face, Lavater was able to speak definitely of the characteristics of such men as Mercier and Mirabeau; but, on the other hand, Lavater mistook the profile of an assassin for that of the poet Herder.

Any one would be rash to give a character or receive a

friend solely on the strength of a face or the shape of a head. Every one admits that there is something in phrenology, and has special instances to tell of persons having had their peculiarities told by phrenologists, just, as it seems, every one has marvellous cures by bone-setters, and wonderful, almost miraculous, recoveries which might be placed under the group of faith-healing.

The occasional correct diagnosis does not make the physician, and habitual character-reading is not yet attained by the physiognomist or phrenologist.

Men are not made wholly given to one set of ideas, and therefore they have more than one set of expressions; and the person with the most experience of the world, the most highly-civilized, is the one least likely to show by his face what he feels.

If words, like nature, half-conceal the soul within, the features conceal a good share also.

The savage is supposed to conceal his feelings of acute physical pain, and the woman of society conceals under a smile the most distracting moral torture.

The more scientific consideration of expression by Bell and Darwin is discussed by our author in an appreciative way.

He points out the depth of the abyss between the method of Dalla Porta and that of Darwin, and points a way for further progress. In detail, the human face is considered, and the best methods for recording observations on the various features are given, the author pointing out the immense difference between merely studying the features at rest and in movement; and in this respect Dr. Warner and Prof. Mantegazza approach one another.

We must refer the reader to the author's analysis of the face, and his method of arranging the types.

In each case the history and authorities are given, and the author's opinion or method stated in a judicial way before giving examples.

The first part of the book, consisting of five chapters, has to do with anatomy, that is, the features passive; and the second treats of the functions of these features, their physiology, and their moral and intellectual relations.

We hardly agree with the dogma of Mantegazza, that after the eye the forehead is the most faithful interpreter of intelligence. Eyes are deceptive, and foreheads of the largest size and best form may conceal the brain of a very weak man; in fact, we believe the lofty forehead and the

long, lank beard and whiskers occur as often in men of acute foxy natures as in men of profound mental ability. Many pleasant recollections are brought up by the apt quotations of our author, and these are very numerous in reference to the forehead.

Eyes and eyebrows receive full attention, the latter being of great diagnostic value.

We are at present watching all our friends to see if they have an inclination of the tips of their noses to the right, as Mantegazza says he finds this common, and thinks it due to the method of blowing the nose, common to civilised people.

The mouth is, according to our author, much more seductive than any other feature. "*La femme, dont les yeux nous rendents amoureux, nous enthousiasme, nous exalte. . . . Mais celle dont la bouche nous fascine, elle nous enlace, elle est déjà à nous, au moins dans la monde irresponsable des désirs.*" The chin is looked upon as one of the English strong points. Remarks more or less complimentary to dimples are made; and after speaking of the teeth, it is suggested that good dentists should be considered as worthy of all honour. We might go from page to page discussing the many points of interest developed by our author, but it must suffice now to pass rapidly over the subjects which form the mass of the book.

The features in action are carefully, but not mechanically, studied, quite enough anatomy being brought to bear on the subject, yet not too much to weary one. "*La mimique*" is a transformation of force from the nerve centres; it is, in fact, the combination of actions associated with expression of sentiment. The alphabet of this expression is considered, and then the combinations as seen in pleasant and painful expressions, the pleasures and pains which produce similar expressions being compared, and by this means many interesting similarities are noticed. The pleasures of the higher senses often are expressed very similarly to the lower or more animal pleasures. Musical expression is, according to Mantegazza, very nearly allied to amorous expression, and the pleasures of smell are voluptuous in their expression; and this, he maintains, snuff notwithstanding.

There is not perfect agreement with Darwin in his three-fold division of the expression of the emotions, and our author prefers to divide them into the defensive and the sympathetic; and in this we think he, from his own standpoint, is right, though Darwin's division is more complete.

After studying the expressions in detail, he gives his opinions on general expressions, or expressions of general states and conditions, and then on racial and professional peculiarities, the latter naturally conducting to the reserves and untruths of expression.

Criteria for appreciating the force of the expression are given.

The final chapters are concerned with the judgments on human physiognomy. Briefly stated, there are five problems presented by each human face. What is the

1. State of health or disease ?
2. Degree of beauty or ugliness ?
3. Moral standard ?
4. Intellectual power ?
5. Race ?

These lead to five judgments.

1. Physiological.
2. Æsthetic.
3. Moral.
4. Intellectual.
5. Ethnic.

But enough has been said to show that we consider the book eminently readable and full of points of interest, that it is brilliantly-written, and merits the attention of the general physician quite as much as the psychiatric.

Cutaneous Nerve Supply. JACOB HEIBERG. Translated by W. W. WAGSTAFFE, F.R.C.S. Baillière & Co. 1885.

The translator, whose long, practical knowledge of anatomy gives him authority to speak, thinks the small book before us one which will be found useful to the student, and still more to the busy practitioner.

The plates, which constitute the real book, are rather violently coloured, but are thereby made plain.

The cutaneous supply of the body is given, and at a glance the general source of nerves and their distribution are seen. All scientific surgeons appreciate the importance of correct knowledge of nervous distribution, and physicians of late years have run surgeons hard by their careful study of nervous supply and distribution.

In years gone by, John Hilton built up his reputation as a far-seeing surgeon on his exact knowledge of anatomy; and

all who were his dressers at Guy's had reason to remember his trenchant criticisms on the cause given for pain in any patient under observation. In every case of pain the painful spot, being first carefully mapped out and limited, the nervous supply, with the origin and course of the nerves, had to be made clear, and the possibilities of pressure or local injury at various parts of the course discussed. By this means many vague symptoms were traced to a definite and removable cause.

The book before us would have been of great service to us in those days, and will be found to supply a want in a simple and handy form.

From an artistic point of view, we cannot admire several of the plates; and must say that, since to the anatomist and medical practitioner all things human are pure, the position of the hand in Plate viii appears rather absurd, unless it allows the figure thus to do for either sex. We are specially glad to welcome this translation of Mr Wagstaffe's as a pioneer of other, and, we trust, original work.

“*Idiotophilus.*” By PASTOR H. SENNELMANN, Dr., Director of the Alsterdorf Institution for Feeble-minded Children, near Hamburg. Norden, Diedr. Soltau's Verlag, 1885.

This important and comprehensive work on idiocy consists of three parts, viz.:—(1) “A Systematic Manual of the Ameliorative Treatment of Idiots;” (2) “Aphorisms;” and (3) “Life Pictures of Idiots and of Idiot Institutions.” The name of Dr. Sennelmann has long been familiar to us as a prominent member of the Conference of Directors, Medical Officers and Teachers of German Imbecile Institutions, and as a frequent contributor to its organ, the “*Zeitschrift für die Behandlung Schwachsinniger und Epileptischer,*” and we are glad to have his views collected into the easily-accessible form of a volume. The first part is divided into three sections; first, theoretical; second, historical; and third, practical; and in each of these sections we find evidence of original thought, careful research, and matured experience. The theoretical section first discusses the ontology of idiocy, and then treats of the psychical and physical symptoms; afterwards reviewing its etiology. We confess ourselves agreeably surprised to find the author, who (we believe) is not a medical man, adopting the physical rather than the

metaphysical view of the subject, and referring frequently to the writings of Séguin, Esquirol, Griesinger, Ireland, and other medical authorities. This is his definition; "Idiocy or Idiotism is that mental condition in which, from physical causes or beneath a combination of factors of the physical life, the normal development of the intellectual powers is either rendered impossible, or prematurely retrogressive, or is checked." To define is proverbially difficult, and our only criticism of the above shall be that it appears to us to cover a little too much ground, and, leans to the new Nomenclature of the Royal College of Physicians, which causes confusion between the boundaries of juvenile imbecility and dementia. However, as our author quotes the various definitions of idiocy by some dozen authorities we are allowed ample choice. With regard to symptomatology, the peculiarities of will, intelligence, and disposition found amongst imbeciles are first discussed, and then we have an account of some of the abnormalities in their nerve-centres and of their physical deformities and functional derangements; a few words as to the duration of life and causes of death of idiots closing the chapter. *Ætiology* is next reviewed, and it would seem rather from a general than a pathological standpoint. The historical section gives a full report of all that has been done in Germany in the way of establishing institutions for idiots, and glances at what has been done in other countries in the same direction, and appears for the most part accurate. We notice, however, a curious error as to Earlswood, which is said to have become, after the separation of Essex Hall as the Eastern Counties Asylum for Idiots, the special asylum for the seven northern counties, the facts of the late Prince Consort having laid the foundation-stone of the Red Hill building, and of the Northern Counties Asylum (at Lancaster) having by the Queen's permission assumed the name of the Royal Albert Asylum, probably accounting for the confusion. However, in the table of institutions in German and English-speaking countries subsequently given, the matter is correctly stated. A polyglot and apparently comprehensive bibliography of idiocy (occupying 12 pages) closes this section. The practical portion is thoughtfully written, and goes very thoroughly into details of institution organisation, giving copies of the dietaries and time-tables of many of the German institutions, and of the schedules of questions asked upon the admission of inmates.

The second part of the work, the so-called "Aphorisms," consists of a number of brief essays upon various subjects more or less connected with idiots and their care. "Dic cur hic," for example, is the heading of a disquisition upon the qualifications of a true idiot-helper. "Aliis in serviendo ipse consumer," is another aphorism. "Docendo discimus," and "Restraint and no Restraint"—(the latter printed in English)—are also headings which catch our eye; and there is a paragraph on the mutual relations of physician and director. We congratulate Dr. Sengelmann on his experience of "hand-in-hand" co-operation of twenty years standing with the medical staff of his institution, and could wish that the same harmonious result were always experienced where superintendent and doctor are not one and the same person.

With regard to the third part—the "Life Pictures"—our space only allows us to say that it contains much interesting reading, though of course rather of a graphic than of a scientific character. The motto of one of its sections, "Lost and Found," will give an idea of its contents.

The three parts comprise upwards of 600 pages, and are printed in clear type upon good paper, important recommendations in the case of a book printed in the German character. Dr. Sengelmann deserves much credit for the industry and research which this work displays.

A Statistical Inquiry into the Nature and Treatment of Epilepsy. By A. HUGHES BENNETT, M.D., Phys. to the Hospital for Epilepsy and Paralysis; Ass. Phys. to the Westminster Hospital. London: H. K. Lewis, 1884.

The three papers comprised in this inquiry are reprinted from the medical journals in which during the period of the last five years they have appeared. The papers are of different value; the second and third, or those dealing with the therapeutics of epilepsy, appear to us of more value than the first, which treats of the etiology and symptomatology of the disease. In the first chapter the etiology is considered under the headings, Predisposing and Exciting Causes. Neither section calls for special comment. In the section on symptomatology, however, we find some singular inaccuracies in the figures, *e.g.*, on p. 11, in the figures which give the percentages with reference to premonitory symptoms. It is the second pair of numbers to which we call attention.

Again, on p. 14, the last list of numbers contains absurd misprints, unless indeed the figures overlap. This last, we suppose, must be the interpretation, but a word of explanation in the text would have made matters perfectly clear. To some of the tables, at least, a further objection must be made. The original figures are analysed, and sub-analysed, and again analysed, and the results on a lessening figure always given in percentages. The result is that these percentage figures obtain a somewhat fictitious value—a dignity they can scarcely lay claim to. As an example we find on p. 11, 100 unselected cases of epilepsy, showing in 62 per cent. the severer form; in 10 per cent. the lighter form; in 28 per cent. the two forms combined. So far so good, but the next table takes the above 62 cases and establishes a *percentage* on them, and the results of this analysis are again utilized for further analysis, whence it happens that this time some forty cases are analysed, and the results given in percentages. A continuance of this process would end in a *reductio ad absurdum*, for percentages established on small numbers are surely worthless; but this reduction is actually attained to in the list on p. 17, where we see 10 cases analysed, and the results given in percentages! Two cases figure accordingly as 20 per cent., and one case as 10 per cent.! Such treatment is indeed to abuse statistics.

The second paper deals with the action of the bromides on epileptic attacks, and contains some interesting results. An analysis of 117 cases of the administration of bromides in all forms of epilepsy is given. The conclusions which are summarised at the end of the chapter are as follows:—

“1. In 12·1 per cent. of epileptics, the attacks were completely arrested during the whole period of treatment by the bromides.

“2. In 83·3 per cent. the attacks were greatly diminished, both in number and severity.

“3. In 2·3 per cent. the treatment had no apparent effect.

“4. In 2·3 per cent. the number of attacks was augmented during the period of treatment.

“5. The form of the disease, whether it was inherited or not, recent or chronic, in the young or the old, in healthy or diseased persons, appeared in no way to influence treatment, the success being nearly in the same ratio under all these conditions.”

The first four propositions are statements of facts, and upon them Dr. Hughes Bennett maintains with justice that epilepsy is eminently a treatable disease, and, says the writer, "I believe that of all chronic nervous diseases, it is the one most amenable to treatment by drugs." Unfortunately the class of chronic nervous affections is, as a class, eminently untreatable, and to be *facile princeps* might yet mean but slender praise. But, of course, we have here the actual results obtained by the author to fall back on.

Proposition five contains some important statements, but they do not rest on so firm a basis as the preceding. Thus the statement that the form of the disease in no wise affects its readiness to be treated rests on the very unequal comparison of 47 cases of E. gravior with 18 cases of E. mitior. Dr. Bennett himself points this out. The same criticism applies with added force to the tables dealing with the diurnal and nocturnal forms, the numbers here being much smaller. It is, however, the last table in this section which is least trustworthy, the numbers there compared being but seven against five. On this table, again, Dr. Bennett himself comments, pointing out that the numbers are too small to permit of any reliable dictum, and yet the dictum immediately follows.

Criticism on this multiple fifth proposition is the more needful, that the statements therein contained are, to say the least, startling. That treatment should be in no wise modified by the type of the disease, *i.e.*, severe or light; by the time the disease has lasted, *i.e.*, recent or chronic; by the age of the patient affected—these are facts, if facts they be, of a new order, but to establish them the evidence would have to be very unequivocal.

Having thus pointed out the defects of this chapter, we must allow that the *method* of analysis adopted is good, and the results gained, apart from the conclusions, of considerable value. Let us hope the author may find time to extend them yet further.

In the last chapter the long-continued administration of bromides is discussed in its effects on the health generally, and specially on these points Dr. Bennett speaks with the authority of a wide experience and careful observation. The tables given in this chapter comprise 141 cases, "all of whom have been constantly under the influence of the drug for periods varying from one to six years," the minimum dose of the drug, it must be added, being one drachm and a half

daily. The details of four cases which the author had under observation during six years are given subsequently to the tables, and finally there is added the case of a man, aged 30, who, during five years, had taken four-and-a-half drachms of the bromide daily! The conclusions arrived at from this inquiry are:—

1. That the drug is very innocuous.
2. That in this respect epileptic patients are far more tolerant than healthy people.
3. That what deleterious effects do arise in the epileptics tend to wear off as the bromide habit is established.

The importance of these conclusions is very great, and for the painstaking investigation, which goes a long way towards their establishment, we are grateful to Dr. Bennett. There is but little doubt that a timid therapy bears, or should bear, the blame of much of the scepticism now prevalent as to the efficacy of drugs. After Dr. Bennett's recorded experience there will certainly be less excuse for a timid administration of the bromides in cases of epilepsy, and therefore more chances to the drug of a fair trial.

H. S.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *American Retrospect.*

By D. HACK TUKE, F.R.C.P.

The Original Thirteen Members of the Association of Medical Superintendents of American Institutions for the Insane. By JOHN CURWEN, M.D., Secretary of the Association. 1885. Warren, Penn.

Memoir of Thomas S. Kirkbride, M.D., LL.D. Prepared by direction of the Association of Medical Superintendents of American Institutions for the Insane, by JOHN CURWEN, M.D., CHARLES H. NICHOLS, M.D., JOHN H. CALLENDER, M.D. Read at the Meeting of the Association at Saratoga, New York, June 16, 1885. Warren, Penn.

Written at the request, in the first instance, of the American Association of Medical Superintendents of Hospitals for the Insane, the Address of Dr. Curwen has been considerably enlarged by interesting biographies of the physicians who founded the Association. These notices, of which we shall give a brief abstract, are accompanied by well executed likenesses. Altogether the book is one of much interest,

more especially doubtless to American alienists, but also to those in our own country, with whom the majority of the names referred to are familiar, and are held in just esteem. These names are Drs. Samuel B. Woodward, Samuel White, Isaac Ray, Luther V. Bell, Charles H. Stedman, John S. Butler, Amariah Brigham, Pliny Earle, Thomas S. Kirkbride, William M. Awl, Francis T. Stribling, John M. Galt, Nehemiah Cutler. Of these two survive, Dr. Butler and Dr. Earle, both of them having now retired from asylum service, but retaining a lively interest in the work to which they have devoted their lives, and upon which they have left their mark.

The Association was formed Oct. 16, 1844, at a meeting held at Jones's Hotel, in the City of Brotherly Love. Dr. Curwen writes: "Meeting upon the evening of the 1st or 2nd day of the Sessions, at the house of the first secretary (Dr. Kirkbride), for social intercourse and interchange of views and plans on those subjects which most fully occupied their thoughts, their appearance was so striking and impressive that, after an interval of almost forty years, it comes before the mental vision of the writer in the most vivid and distinct form. Subsequent intercourse and a more intimate acquaintance with the majority of them served to heighten and strengthen the regard and esteem in which they were held, and to give more thorough understanding of the high aim and principles which actuated them."

Dr. WOODWARD, born in 1777, was appointed superintendent of the State Lunatic Hospital at Worcester, Mass., at the age of 45. Ill-health necessitated his retirement after holding the office 14 years. He died suddenly at Northampton, Mass., four years later, January, 1850. Dr. Woodward was the first President of the Association, one of the Medical Examiners of the Medical School in Newhaven, and took an active part in the establishment of the Retreat at Hartford, Connecticut.

Dr. WHITE was born at Coventry, Conn., in 1777. It is stated that owing to the occurrence of insanity in his own family, he paid special attention to mental affections, and eventually established, in 1830, a private asylum at Hudson, N.Y. Dr. White was the first Vice-President of the Association, and was elected President of the New York State Medical Society, before which he delivered an address which Dr. Curwen states gave one of the best synopses of insanity, especially of its treatment, ever published. He died at Hudson, 1845.

Dr. RAY was, at the time of the formation of the Association, in his prime, "and stood then as he did through all the remainder of his life, among the first of those who there met. With iron-grey hair, and the student stoop of his shoulders, he delighted to gather a small group around him, and discuss the different questions which concerned the welfare of the insane, sitting in that peculiar posture so natural to him, with his head bent forward, his legs crossed, and his hands crossed or folded together on his lap before him. . . . In whatever position in life he was called to act, his sound judgment and well-

matured views always gave him a commanding influence, which he invariably used to promote the welfare of the insane and other afflicted classes." He was President of the Association from 1855 to 1859, and died in 1881, in his 75th year. It is unnecessary to give further details of the life of this admirable man and wise physician, as we have already sketched his career in the obituary notice of him in this Journal.*

Dr. BELL, born in Chester, New Hampshire, in 1806, contributed largely to the establishment of the New Hampshire Asylum, and made an able report on the condition of the insane in that State. In 1836 he was appointed medical superintendent of the McLean Asylum, and entered upon his duties in the next year. Through his efforts this institution was the first in which a circulation of hot water was successfully employed. He visited Europe in 1845, to study institutions for the insane, and after his return he prepared a plan for the Butler Hospital, Providence, Rhode Island, which proved successful. The state of his health obliged him to resign his post at the McLean Asylum in 1856. He not only suffered from lung disease, but his health was impaired by the loss of his children and wife. He retired to Charlestown, but was constantly consulted as an expert. When the Civil War broke out he was appointed surgeon of a regiment of Massachusetts Volunteers, and was shortly promoted to the position of brigade surgeon to General Hooker's Division on the Lower Potomac. On Feb. 11, 1862, he died suddenly in camp, from heart affection. He will be remembered for his recognition and able description of acute delirious mania, which has been called in America after him "Bell's Disease." He was President of the Association from 1851 to 1855.

Dr. STEDMAN was born at Lancaster, Mass., in 1805. He was appointed in 1842 superintendent of the Boston Lunatic Hospital. He remained there for nine years, when he resumed practice in Boston, which he had previously carried on for several years before his appointment. He was elected to the Mass. Senate in 1851, and in 1853 became one of the Governors' Council. He was appointed visiting surgeon to the Boston City Hospital, at its opening in 1864, and died in 1866. Dr. Curwen speaks of "his lucid way of teaching, his quick diagnosis, his wonderful resources in therapeutics, and his manly, decided, and easy methods of conveying his instructions." Dr. Henry R. Stedman, the proprietor of a private asylum in Boston, follows in his father's footsteps.

Dr. BUTLER, who survives his colleagues, became superintendent of the Boston Lunatic Hospital Sept. 16th, 1839, and resigned Oct. 10, 1842. Appointed superintendent of the Retreat for the Insane at Hartford, already mentioned, in May 1843, he remained in charge until Oct. 20th, 1873. "We see as the result of these 30 of the best years of his life, the dreary, cold, dark, and forbidding walls of the narrow passage-ways and comfortless rooms and dormitories of 1843, con-

* July, 1881.

verted into an institution well-nigh perfect in all its appointments—the spacious halls and parlours, ornamented, and made attractive with paintings and engravings and other works of art; the whole structure, from foundation to ceiling, reconstructed and rebuilt, placing the Retreat among the most homelike and cheerful residences of the kind anywhere to be found; libraries of books and the periodicals of the day upon the tables, and in every hall; the ground and lawn, through his agency, converted from an open field to one of the most beautiful of parks. These are among the noble monuments which he has reared and left, giving beauty, comfort, and cheerfulness to the Retreat and its surroundings, and which have and will continue to shed joy and sunshine into many a patient's sad heart, and are admired and appreciated as his work. Yet the most gratifying and glorious result of these years of toil and care is in the restoration of patients scattered up and down through the whole land, whose grateful remembrance he enjoys, and whose blessings will follow him to the end of his days." Dr. Butler was President of the Association from 1870 to 1873.

Dr. BRIGHAM, a Massachusetts man, was born in 1798. After being in practice some years he sailed to Europe in 1828, and made himself acquainted with the hospitals of the countries he visited. On his return he resumed general practice, and removed to Hartford, Conn., in 1831. While residing there he wrote his well-known works, "Influence of Mental Cultivation on Health," and "Influence of Religion on the Physical Welfare of Mankind." Also "An Inquiry concerning the Diseases and Functions of the Brain, the Spinal Cord, and the Nerves." He was elected Professor of Anatomy and Surgery in the College of Physicians and Surgeons, New York City, in 1837. He became medical superintendent in 1840 of the Retreat at Hartford, and only remained there about two years, being appointed superintendent of the State Asylum at Utica, where he commenced the "Medical Journal of Insanity," July, 1844. Unfortunately his health broke down, in consequence of which he went to the South in the spring of 1848, but failed to obtain permanent advantage, and died September 8th, 1849. He filled the office of Vice-President of the Association at the time of his death. We are informed that he materially modified in later life the opinions which he promulgated in his book on the "Influence of Religion."

Dr. EARLE is still living, and consequently Dr. Curwen refrains from giving a biographical sketch of any length. He states, however, that at the time the Association was founded, Dr. Earle "was in the prime of life, and decided in all his convictions. With a large head, fine forehead, and pleasant expression of countenance, he showed the scholar as well as the man of active work." He became superintendent of the Bloomingdale Asylum, New York, April, 1844, and remained in office five years. Compelled by ill-health to relinquish active work, he resumed it when his health was restored, and became superintendent of the State Lunatic Hospital at Northampton, Mass., in

superintendent. . . . He continued in charge until 1850, when he was displaced by that system of political appointment which has so unfortunately prevailed in Ohio from that day to this." He was President of the Association from 1848 to 1851. Dr. Awl died in 1876.

Dr. STRIBLING was born in 1810, at Staunton, Virginia, and was "never," Dr. Curwen states, "very robust in build or health, but managed, by care and discretion, to accomplish a large amount of work for the insane, and to attach to him, by the gentleness of his manner, and the persuasive tone of his voice, all those with whom he was called to associate." Dr. Stribling spent one session at the University of Virginia, and in the following year took his degree in Philadelphia. He then commenced the practice of his profession in his native town, but in 1836, young as he was, the Board of Directors of the Western Lunatic Asylum, Ohio, appointed him medical superintendent, and allowed him to make a tour of observation through the Middle and Northern States to inspect the best regulated institutions of the insane.

He prepared the law regulating institutions for the insane in Virginia, enacted by the Legislature in 1840-1841. He died in 1874.

Dr. GALT was, like the preceding physician, born in Virginia. The year of his birth was 1819, and he was remarkable from childhood for the somewhat unusual combination of studiousness and athletic ability. In 1841, the year in which he received his medical degree from the University of Penn., he was appointed medical superintendent of the Eastern Lunatic Asylum at Williamsburg, his native town. Dr. Galt was a considerable writer, and was the author of a work published in 1846, entitled "Treatment of Insanity." His general culture was remarkable. "He was a great linguist, for, with the exception of the Russian and Turkish languages, he required no one to translate for him the tongues of the other nations of Europe. It was his daily habit to read a certain number of pages of Xenophon, Thucydides, or some other standard Greek author. In addition he had turned his attention to the languages of the East, and was so good an Orientalist that he read the Koran in the original Arabic." Dr. Galt died after a short illness in May, 1862.

Dr. CUTTER was born at Jaffey, New Hampshire, in 1777, and was rather under the medium height. He was endowed with great energy and determination. Having received the degree of M.D. in 1817, he commenced practice in the following year at Pepperil in Mass. Having received insane persons into his family, the number increased so rapidly that he was obliged to build additional accommodation in 1834. He was associated afterwards with several medical men in the charge of his patients, and in 1848 Dr. J. G. N. Howe purchased part of the building, and was connected with him in the care of patients, but they were burnt out in the summer of 1853. Dr. Curwen says, "When the institution, which he had built with great labour and expense, was burnt, and the work of years swept away in a few hours, he returned to

the practice of medicine with all the ardour and energy of his youth." Dr. Cutter died in 1859, aged 72.

The foregoing brief sketch of the original "Thirteen Members" may serve, imperfect as it is, to convey an idea of the kind of men who met together on the 16th day of Oct., 1844, to establish a Psychological Association in the United States, varying in years from 35 to 60, but united in the desire to promote the interests of the insane.

Dr. Curwen has performed his task in a praiseworthy manner, and so far as we are able to judge, with great impartiality. Of his modesty he affords conspicuous evidence when he writes, "All failures and defects are to be charged to the writer, whose aims and intentions were higher and better than his performances."

2. *Psychological Retrospect.*

By A. T. MYERS, M.D. Cantab.

Revue Philosophique, &c.

The Life-History of a Case of Double or Multiple Personality.

In the last September number of the "Archives de Neurologie," M. Jules Voisin, of the Hôpital Bicêtre, has published an interesting account of "A case of hysteria major in a man with Double Personality." The patient had before that attracted some notice in France for the same symptoms, and M. Camuset (of the Bonneval Asylum) has published a description of his very unusual state in 1880 and 1881 (*Annales Médico-Psych.*, 1882, p. 75). Some important additions to our knowledge have been made by MM. Bourru and Burot (of Rochefort), of which the chief have been published in the "Revue Philosophique," Oct., 1885, and "Arch. de Neurol." Nov., 1885, and we may expect to see more in the "Annales Médico-Psychologiques." They have very kindly allowed us to use some recent observations which they have privately sent us, and it has seemed a good opportunity for a brief retrospect of the whole case.

Louis V— was born at Paris in 1863. He was an illegitimate child, and his mother of bad character, and probably hysterical temperament. As a boy he lived chiefly in the country, at Luysan and Chartres; was ill-treated by his mother, quite uneducated, a waif and stray. When he was ten years old he was convicted of theft, and sent to the Reformatory of Saint Urbain in 1873, where he stayed nearly seven years, till March 22, 1880. During these years he was employed at first in the fields and vineyards, and given a good primary education. He was obedient and intelligent, and did good work both out of doors and at his books. His health seems to have been good, except that he showed his nervous temperament as early as at five years old,

when he had some convulsions, and again when seven and eight. Whilst living at St. Urbain in 1879 (or more probably in 1877, as the most recent researches of MM. Bourru and Burot seem to show) he was much frightened when at work in the fields by a viper, which wound itself round his left arm, but did him no serious mischief. The same evening he began a long series of convulsions and hysterical attacks, which left him in a state of hysterical paraplegia. After some time he was not judged fit to remain at St. Urbain, but was sent to the asylum at Bonneval, on March 23, 1880, with the medical report that he had had epileptiform attacks, which came on periodically and were growing more severe; both legs were paralysed and stiff. His intelligence was not affected. At Bonneval he came under the notice of M. Camuset, who reported that on admission both legs were much contracted and atrophied from disuse. He was a quiet boy of 17, grateful for any kindness shown him, ashamed of his thefts seven years before, and with a good memory of his previous life. He told the story of his fright at seeing the viper, and how he lost consciousness on coming home very soon afterwards, and when he recovered, he stated that he had had a nervous attack, and that he had had afterwards several others which gradually made his legs too weak to walk, and drew them up into a condition of contracture. He had almost entirely forgotten how to read and write. A tailor's work was thought suitable to his paraplegia, and he was set to that and worked well at it for two months. However, in May, 1880, whilst still at Bonneval, he had a severe hystero-epileptic attack, beginning with short tonic spasms and going on for a night and a day with clonic convulsions, with a few short intervals of coma; the aura started from the epigastrium, the legs moved as readily as any other part; no local pressure had any good effect in stopping the attack. Next day he passed into an ecstatic phase and lay on his back smiling and staring upwards. After about fifty hours altogether, he fell into a quiet sleep, and when he woke from that felt no paraplegia apparently, asked for his clothes and got up under the impression he was going to work in the fields as he used to do at St. Urbain more than three years ago. He could walk easily, though his step was a little shaky from the atrophy of his legs; he explained that by saying he was rather tired. He was quite persuaded he was at St. Urbain, recognised no one about him, asked for those he had known previously, and remembered having been frightened at the viper, but nothing after that. At first M. Camuset was inclined to believe that this was a hoax; but after various tests, such as suddenly taking him into the tailor's shop and finding him entirely ignorant of it and unable to handle a needle, the idea of dissimulation was given up, and his condition was accepted as one of double personality analogous to Dr. Azam's case of Félicité X—. His character was very much changed; he had been quiet, industrious, and orderly; he became what he had not been known to be before, at least for the last seven years that he had been under observation,

quarrelsome, greedy and violent. He was once caught committing theft, as he had done before in 1873. He often completely lost his temper, but not even then could any trace of memory of his life between the accident with the viper and the long crisis in May, 1880, be proved. He had a slight hysterical attack, and for a day some hysterical paraplegia, and some variable cutaneous anæsthesiæ, but for the next 13 months which he spent at Bonneval no material change took place, and he left on June 14, 1881, when he was just eighteen. For the next two years his history is more difficult to trace. He spent a short time near Chartres with his mother; then went as an agricultural labourer to Macon, where he fell ill, and was in hospital, and on Sept. 9, 1881, less than three months after leaving Bonneval, was taken in at the Bourg Asylum for 18 months, under the care of M. Lacuire. He left in April, 1883, and found his way somehow to Paris, where he visited the Hôpital Ste. Anne for a short time, and finally, after a short spell of four months at most of freedom, was arrested again for theft, condemned, and sent on Aug. 31, 1883, to the Bicêtre, with the certificate of unsound mind and epilepsy. There he remained under the observation of M. Jules Voisin for 16 months, and of this period M. Voisin has given us some very interesting particulars (*"Arch. de Neurol."*, Sept., 1885, p. 212-225). He was put among the patients capable of work, and took up the occupation of tailor, which he had pursued for two months three years and a half ago at Bonneval. After nearly five months, on Jan. 17, 1884, he had a violent attack of hystero-epilepsy, and for the week following it some very anomalous, and at times alarming, symptoms, at first of pulmonary congestion and hæmoptysis, without sign of tubercle or fever, and probably of nervous origin, and also of occasional attacks of very rapid breathing, with some complete pauses, from which he could only be roused by artificial respiration; the pulse, too, was at times nearly imperceptible, and ether was injected to revive him. He got amblyopia of the left eye, cutaneous hemianæsthesia of the left side, and increasing pain under the left axilla. Pressure over this painful region brought on a second violent attack of hystero-epilepsy on Jan. 24, a week after the first. He went through the emotional posturing, the opisthotonus, the attitude of crucifixion, which are so familiar at the Salpêtrière, and sank finally to sleep, awaking shortly with an altered memory, and developing, two days later, right hemiplegia with contracture. He remembered then the later part of his stay at Bonneval, under M. Camuset, when he had been disorderly and non-paralytic, but not the earlier part when he had been quiet, had had paraplegia and contracture and had begun to learn to be a tailor, nor anything of the last five months at the Bicêtre, when he had been going on with his tailoring. He remembered also something of his earlier healthy life at St. Urbain, and his work in the fields, but nothing of his invalid time there after his accident with the viper. He was quiet and orderly in his habits,

as he had been in the latter part of his stay at St. Urbain, and first two months at Bonneval, where he had had paralysis and contracture before. After due consideration, M. Jules Voisin came to the conclusion, in which M. Camuset and Prof. Ribot agreed, that this might be explained as a case of double personality, or at least as of the same class as Dr. Azam's case of Félicité X—. The patient might be considered to be in his "*état prime*," to use Dr. Azam's phrase, when he came to the Bicêtre, and now to have lapsed again into his "*état second*," of which he had had previous experience after the accident with the viper. These two periods of his second state had been characterised by the cardinal feature of hysterical paralysis with contracture, though it had been differently distributed, for in the first he was paraplegic, in the second hemiplegic. The condition as regards memory had not been the same as in Dr. Azam's case. Félicité X—, when in her second state, remembered all her previous life; when in her first state, remembered all except the parts passed in her second state. M. Voisin's patient in his second state remembered comparatively little of his previous life, and nothing at all of the previous period in his second state; in his first state remembered more of his previous life, but again nothing at all of his previous second state; the memory of which, in fact, seemed completely gone. This latter period of "second state," spent at the Bicêtre under M. Voisin, lasted nearly three months, and went off quite unexpectedly after a slight hystero-epileptic attack, of which at that time he had many, on April 17, 1884. He was found in tranquil sleep after the convulsions, with no contracture, and his hands clasped behind his head. When he woke in the morning he was astonished not to find his clothes at the foot of his bed, and thought they must have been hidden for a practical joke, for he imagined it was Jan. 26, and that he must get up early and go to work as he had been used to do three months ago. He had no recollection of right hemiplegia or contracture, or anything that had happened in the last three months, and was surprised to see leaves on the trees and new faces in the wards. His right arm and leg were not used quite freely for the first few days, but seemed afterwards normal; the right hemianæsthesia, however, persisted. His manner reverted to that of the noisy quarrelsome thief he had been at Bonneval in the latter part of his stay there. He had many more epileptiform attacks, but none led to any further access of his second state except on June 10, 1884, when he had right hemiplegia and contracture and their accompanying mental symptoms, but for a few hours only.

During all his stay at the Bicêtre, it was found very easy to induce a hypnotic condition, and many experiments were tried. As soon as he became hypnotised he always lost his right hemiplegia and contracture completely, and moved quite normally, but had no recollection of this when his hypnotism had passed off. In the first stage of hypnotism, both eyes were shut

normally; on opening either of them the corresponding side of the body became cataleptic; on opening both, the whole body. If he was talking or reciting in the hypnotic state, and his right eye was opened, he would not only become cataleptic on the right side, but also aphasic. M. Voisin attributes to this opening of the right eye an inhibitory influence on the left hemisphere, and consequently on the normal centre of speech. When the eye was closed again, he resumed his reading or speaking where he had left off. The opening of the left eye in the *état prime* had no effect on speech; but in the *état second* his words and fashion of talk were very childish, almost like those of a baby; he used phrases like "me want drink" (*moi vouloir boire*); and in that condition the opening of the *left* eye, and not of the right, stopped speech; for, as M. Voisin suggests, the infantine imperfect character of the speech, joined with the paralysis of the right side, tend to show that in this *état second* very possibly the left hemisphere was out of work, and the right hemisphere was taking the lead in this childish speech as well as in motion, and the right hemisphere would naturally be the one influenced by the left eye. Several attempts, too, were made to change the contracture from the right side to the left, by injecting pilocarpin on the right side. These were only partially successful; the left side became hemianæsthetic and contracted, but only the right arm became relaxed, the right leg remaining contracted. The speech centre, however, seemed to have shifted sides, for then it was affected by shutting the right eye and not the left; that is to say, it had become normal instead of abnormal, as it was before the pilocarpin was used. The frequency of the convulsive attacks made all attempts at stopping them important, and it was accidentally discovered that, as a rule, strong tension of the patellar tendons stopped a crisis; and sharp pinching of the tendo Achillis when tried gave equally good results. When he was not in a fit, however, a tap on the patellar tendon was apt to bring one on. No other point of pressure or other action was found to be of any use. When hypnotised, he sometimes had a confused memory of his early childhood, and talked and acted as if working in the fields at St. Urbain, without any memory of Bonneval or Bicêtre; showing a third state, in fact, not strictly included in either the *état prime* or the *état second*.

After about 16 months at the Bicêtre, on Jan. 2, 1885, he stole some money and clothes from a hospital attendant, and made his escape. He came to Rochefort, and on Jan. 30 enlisted in the Marines for the Tonquin war. He could not refrain from stealing again, and was arrested for it on Feb. 23. At the trial by court-martial he was convicted, but, being considered of unsound mind, was handed over, on March 27, to the asylum authorities, and there came under the observation of MM. Bourru and Burot. On the evening of the day of admission to the Rochefort Asylum he had a violent hystero-epileptic attack, lasting nearly 48 hours, and emerged from it in a state of right

hemiplegia and anæsthesia. That remained his ordinary physical state at Rochefort. The sight of the right eye was indistinct, and it made some mistakes with colours, which were not shared by the left eye. His mental condition was one of excitement; he was arrogant, violent, coarse in his language, but intelligent and observant. His speech was indistinct, from his clipping the ends of his words; he could read and learn by heart easily, but could not write, owing to paralysis of his right hand. His memory included only the second part of his stay at Bonneval, after the paraplegia had passed off, and the latter part of his stay at the Bicêtre; between these there was a gap of about four years, of which he knew nothing, and of the earlier part of his life (about 17 years) before Bonneval, he was equally forgetful. MM. Bourru and Burot then began the trial of metallotherapy on his obviously hysterical right hemiplegia. By laying a steel bar on the paralysed right arm, it was very soon found that the paralysis shifted from the right side to the left. That was not an uncommon phenomenon and not unexpected; but what surprised the experimenters was a sudden and complete change in the mental condition accompanying it. The violence and excitement were gone; V— was now shy, quiet and respectful, speaking easily, courteously, and clearly. He read well and wrote fairly well. He knew nothing of the place where he was, or of the people round him, but imagined that it was Jan. 2, 1884, and that he was back again at the Bicêtre, Salle Cabanis, No. 11. He was sure he had seen M. Voisin the day before, and that he was coming again very soon. Of the intervening 15 months, he remembered nothing; he had never been at Rochefort, never heard of the Marines or the war at Tonquin. All he could remember was that he had been at the Hôpital Ste. Anne, ever since a child as he supposed, for he would recall nothing before it, and then had come on to the Bicêtre.

A second experiment was made on him in his chronic state of right hemiplegia and violence. The right arm was touched by a magnet (and afterwards it was found that the application of nitrate of mercury or chloride of gold was followed by the same symptoms), and a third state was induced in some respects different from the last. The hemiplegia changed to the left side, but did not affect the face as it had done before; the manner was quiet, and the speech clear and courteous as before, but the memory different. He fancied he was in the Bourg Asylum in August, 1882, and could only remember some part of the previous year spent at Macon. Of external affairs all that he knew was that France was at war with Tunis.

A fourth modification was produced by putting a magnet on the back of his neck. Both his legs became paralysed in a state of rigid extension, and there was anæsthesia of the legs and the lower half of the body as well. He was very well behaved, but shy and timid. There was no clipping of the words, but his phrases and manner of speech were childish. He could not read or write or add up figures.

He thought he was at Bonneval, in his old paraplegic state of 1880, and expected to see M. Camuset and others whom he had known there. His business he said was that of a tailor, and he could sew well. He could remember being paralysed at St. Urbain a few months back, but not the accident with the serpent, or anything before it. He had never heard of Victor Hugo, or Chartres, or Macon, or Bourg, or the Bicêtre, or Rochefort.

These artificial conditions of consciousness were not kept up more than half-an-hour or so; no attempt was made to keep them up; but further means were tried with a view of curing him entirely of the right hemiplegia and violence, which was the constant condition to which he returned after these interludes.

After various unsuccessful attempts, he was put in an electric bath and all paralysis and anæsthesia disappeared, and he reverted to the condition and memory he had had at St. Urbain, 22nd of March, 1877, when he was only fourteen; his manner was child-like, he knew nothing about paralysis, but could tell the story of his life up to fourteen. The same condition—a fifth state—could be produced by a magnet on the top of his head. McMahon, he said, was President of the Republic, and Pius IX. was Pope, as in 1877. All that had happened for the last eight years he had forgotten. When the accident with the viper was mentioned, he went into a hystero-epileptic fit.

Finally, the application of soft iron to the right thigh was followed by much convulsive disturbance, contortions, opisthotonus, and chronic movement, and after that was past, he was left in a sixth state, a figure very unlike the timid child of the last tableau. He thought it was March 6, 1885, and that he was a soldier in the Marines, with easy manners and no paralysis. He remembered most of his past life; but with some important exceptions, viz.: the period of paraplegia at St. Urbain and Bonneval under M. Camuset, and the period of three months (Jan. 17 to April 17, 1884) of right hemiplegia under M. Voisin at Bicêtre, and some of the other crises which are less perfectly known.

In hope of rendering this somewhat complicated story a little clearer, we have endeavoured to put it into tabular form (see pp. 604-605), which we are very glad to find has been approved by MM. Bourru and Burot. The six states of the patient are represented by six vertical columns, and the memories attaching to them by thick black lines on their left-hand borders. To make it absolutely accurate may perhaps be beyond the care and industry even of MM. Bourru and Burot, or indeed beyond the possibilities of the case, but a roughly-drawn bird's-eye view may be of use.

The operators lay great stress on their observations that not only are these past and forgotten mental states recalled by physical impressions, but also conversely, if a past and forgotten mental state is suggested to the patient as his actual and present condition he accepts the belief, and with it comes back his past physical condition; for

example, if V— was told positively and authoritatively that he was at Bonneval in March, 1880, with M. Camuset, he would not only lose memory both of his subsequent and early life, and take up the boyish manners and tailor's habits of that period, but would also show the paraplegia and contracture of the legs, and anæsthesia of the lower half of the body; and in the same way other suggestions of time and place and mental state brought with them their historically appropriate physical accompaniments.

It is important also to note that the first experiments with metals were made when the experimenters had no knowledge of what had, as a matter of fact, been the history of the past paralyses of their patient; they recovered his history from him page by page as it were, and have been lately taking the greatest pains to ascertain how fully and exactly it represents his real life; and they are fairly well satisfied that though there may be a page or two of memory hopelessly lost at his times of crisis, yet that on the whole his glimpses into the past and his temporary rejuvenescences, represent historical realities; the "*personnalités provoquées*" all bring him before us as he once was. That there had been so much careful observation of his previous life is fortunate, but it was a life particularly hard to trace, and some points appear in his recollections of which the contemporary records give no account.

MM. Bourru and Burot do not feel M. Voisin's or indeed any theory of double personality sufficient to cover the facts of the case as they have shown them; they consider it a case of multiple personality, but they regard any exact interpretation as at present hazardous. They are inclined, however, to believe in a dual action of the brain, and in the probably unstable predominance of either hemisphere in a case such as this; and they point to the imperfect speech and violent character associated with the right hemiplegia at Bicêtre and Rochefort, in contrast with the clear speech and self-controlled manners which went along with left hemiplegia at Ste. Anne, and Bourg, and Macon, as showing the different tendencies of the supremacy of the right and left hemispheres. But the facts to the best of our knowledge are unique, or nearly unique, and are worth some study as bearing on some very difficult questions, and that can be our only excuse for putting them forward, as we have done, at some length. The patient is still under observation at the asylum at La Rochelle, under charge of M. Mabille, and there are ample opportunities for further elucidation.

TABLE OF LOUIS V—'s SIX STATES AT ROCHEFORT, 1885.

	1	2	3	4	5	6
Paralysis	Right hemiplegia.	Left hemiplegia, affecting face.	Left hemiplegia, not affecting face.	Paraplegia.	Paralysis of left leg.	No paralysis.
Anaesthesia	Right side.	Left side.	Left side.	Of lower half.	Of left leg.	Hyperaesthesia of left leg.
Character	Violent.	Quiet.	Quiet.	Shy, speech childish; tailor.	Obedient; boyish.	Respectable.
Education	Fair.	Good.	Good.	Bad.	Good.	Moderate.
<i>Esthiologies</i>		Steel on right arm.	Magnet, &c., on right arm.	Magnet on back of neck.	Magnet on top of head.	Soft iron on right thigh.
Dynamometer.	Rt.=0 Lt.=80lbs.	Rt.=80lbs. Lt.=0	Rt.=80lbs. Lt.=0	Rt.=45lbs. Lt.=41lbs.	Rt.=40lbs. Lt.=44lbs.	Rt.=68lbs. Lt.=70lbs.
DATE.	ATTACKS.	HISTORY.				
1863, Feb.		Born at Paris.				
1863-1873.		Lived at Laysan and Chartres; ill-treated by mother.				
1873, Sept.		Sent to St. Urbain; employed in fields and vineyards; well taught.				
1877, March.	Severe after fright from a viper.	Paraplegic at St. Urbain.				
1880, March.		Went to Bonneval (M. Camuset) learnt tailoring.				

PART IV.—NOTES AND NEWS.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Quarterly Meeting of the Medico-Psychological Association was held at Bethlem Hospital, St. George's Road, S.E., on Tuesday, 17th November, 1885. In the unavoidable absence of the President, Dr. Eames, the chair was occupied by the Ex-President, Dr. Rayner. There were also present Drs. S. H. Agar, Bryan, C. S. W. Cobbold, David Bower, F. Pritchard Davies, F. G. Gayton, W. J. Mickle, J. D. Mortimer, Conolly Norman, B. Nowell, W. H. Roots, G. H. Savage, F. Schofield, W. H. Platt, A. H. Stocker, H. Sutherland, Hack Tuke, Thomson, C. M. Tuke, Wright, Outerson Wood, &c.

The following gentlemen were elected members of the Association, viz.:—T. Duncan Greenlees, M.B., Cumberland Asylum, Garlands, Carlisle; C. D. Sherrard, M.R.C.S., 117, The Avenue, Eastbourne; John Powell, L.R.C.P.Ed., Senr. Ass. Med. Off., Joint Counties Asylum, Carmarthen; J. Cumming Mackenzie, M.B., C.M., Ass. Med. Off., Northumberland County Asylum, Morpeth; Rows Nowell, M.R.C.S., Camberwell House; Vincent Koch, M.B., C.M.Ed., Hull Borough Asylum, Cottingham.

The CHAIRMAN said that the Council had had under consideration the desirability of expressing to the family of the late Lord Shaftesbury the deep sympathy which had been felt by the whole Association in the loss they had sustained, and the Association's high appreciation of the great services which Lord Shaftesbury had rendered to the cause of the insane in England; but his lordship's death having taken place some time since, and the family having been almost overwhelmed with such communications, the Council had come to the conclusion that it would perhaps be better to let the matter pass with that simple manifestation of sympathy and feeling which the news had elicited, recording at the same time their reason for abstaining from taking any action upon it.

This course having been unanimously agreed to,

Dr. CONOLLY NORMAN read a paper "On Some Points in Irish Lunacy Law." (See Original Articles.) In concluding his paper, Dr. Conolly Norman said it was scarcely necessary for him to comment very largely upon what he had written, but it seemed to go to prove, to some degree at least, the great desirability of assimilating lunacy laws in various parts of the United Kingdom, lest one portion should lag so far behind in the matter as Ireland had done. It also proved that the intervention of magistrates, about which so much had been said lately, might become, in the course of time, a very idle form.

The CHAIRMAN, in inviting discussion, remarked that Dr. Norman's paper proved that it was not unimportant that a point of view of insanity which some people might think was almost imaginary (that of looking at lunacy as a crime) should receive consideration. It showed very clearly the very bad result of its being so regarded. No doubt the long association of insanity with criminality which Dr. Norman had described did not end with the proceedings which culminated in admission into an asylum, but pervaded the whole view of the population in regard to insanity. Certainly, the mode of discharge on bail would seem to be one which would require a great deal of amendment.

Dr. BOWER asked whether the initial legal proceeding to which Dr. Norman referred was detrimental to early treatment, or whether people were so accustomed to it that they did not think anything of it, and were quite prepared to go through the form.

Dr. NORMAN replied that he had no doubt whatever that it acted very largely as detrimental to early treatment. Patients' friends had very strong

feelings about bringing their relatives into what seemed to be a court of law, and swearing depositions against them in the patient's presence, as was required by the Irish law. When asked why the patient had been allowed to remain two or three years at home, the answer would be that they did not like to go and swear depositions against him. The proceeding also acted prejudicially on the patient.

The CHAIRMAN asked whether it acted prejudicially on the patient after admission by engendering feelings of animosity.

Dr. NORMAN said he had no doubt that it did so act, and the reason he omitted to say so was because it was so thoroughly familiar to him. The patient almost always said, "I did no harm, but my relatives dragged me before the magistrates and made an affidavit concerning me;" and this feeling would stick to him even after his recovery.

Dr. BOWER said that he had learnt that under the Habitual Drunkards' Act the fact of persons having to go before a magistrate barred about fifty per cent. of possible admissions, the cases frequently breaking down as soon as the patients were told of this.

Dr. PRITCHARD DAVIES said that it was held by very high legal authority in England that a lunatic could not be shut up unless he was a dangerous lunatic—dangerous to himself or others. It appeared that the difference was this—that in Ireland the man was bound to be certified as a dangerous lunatic, whereas in England he only *ought to be*. Then, as regards the provision that any relative or friend might take the patient under his own care and protection by giving bail, what had they in England? A relative might go to an asylum and sign a form, which was absolutely useless, undertaking to fulfil obligations, for the neglect of which there was no penalty. He had known many cases in which relations had said they were perfectly willing to undertake the responsibility, and they had been allowed to remove the patient, signing an undertaking that the patient should be no longer chargeable to any parish, and should be properly taken care of, and prevented from doing injury to himself or others, and yet, within a very few days, they had gone and thrown the entire burden back again upon the parish authorities. It appeared to him that the provisions in Ireland in this respect were infinitely better than in England. In England any three Visiting Justices of the Asylum, without the consent of the Medical Superintendent, could discharge the patient. In Ireland any two Justices could allow the patient to be taken out. The difference was that in Ireland there was the bail to be escheated; in England nothing at all.

The CHAIRMAN said that in England the justices would not allow the patient to go out if they thought he was dangerous. In Ireland he thought they were obliged to discharge, which was a very important difference.

Dr. CONOLLY NORMAN said that the justices had no power to refuse if bail was entered into.

The CHAIRMAN suggested that perhaps the bail might be put up so high as to be prohibitive.

Dr. CONOLLY NORMAN said there was no provision for fixing the bail in the Act. The relatives might go to any two magistrates in the country, and it rested entirely with those two magistrates to fix the bail. Those two magistrates had no connection with the asylum. In point of fact, the bail recognizance was never laid before the asylum authorities at all. It was simply brought before the asylum superintendent, who had nothing to do but to deliver up the patient, however dangerous—"Provided always that nothing herein contained shall be construed to restrain or prevent any relation or friend from taking such person under his own care and protection, if he shall enter into sufficient recognizance for his or her peaceable behaviour or safe custody before two Justices of the Peace, or the Chairman of the Court of Quarter Sessions of the county in which such person shall be confined, or one of the judges of Her Majesty's Superior Courts at Dublin."

Dr. COBBOLD asked whether the superintendent was not consulted beforehand by the magistrates as to the state of the patient.

Dr. CONOLLY NORMAN said the magistrates had no power whatever to refuse. Occasionally magistrates who knew him personally had consulted him, but it was simply a matter of private talk. It might have influenced the amount of bail.

Dr. PRITCHARD DAVIES observed that he could quite see that it would not do to fetter the hands of the executive in regard to the amount of bail. They ought to have discretionary power. The provisions in the two countries seemed almost identical, except that in Ireland there was a penalty and in England there was none.

The CHAIRMAN thought there was a difference, and a considerable one. He should think the English system afforded a much greater safeguard against the letting loose of dangerous lunatics than the Irish one did.

Dr. CONOLLY NORMAN said that the Irish Boards of Governors were not necessarily magistrates, and had nothing to do with the carrying out of the law in that way. It was any two justices, and they had no power to refuse. He quite agreed that when the power was in their hands it ought not to be limited by the amount of the bail being fixed; but the amount they sometimes required was wonderfully small. There was one thing he might add, namely, that it might happen, as it once did to his knowledge, that a homicidal lunatic might murder the person who became bail for him.

Dr. HACK TUKE said that the subject came before the meeting at Cardiff, and the feeling there was very strong that there were defects in the Irish law which should be removed. He thought that Dr. Pritchard Davies would agree that the mode in which cases were taken to asylums in Ireland was very objectionable. He would like to know whether any Bill had been introduced into Parliament to remove those objections. He did not understand Dr. Conolly Norman very clearly to say what he proposed to do.

Dr. CONOLLY NORMAN said he made no suggestion. He had never heard of any Bill being introduced to alter that Act, at least within the last eleven years. The Act was passed in 1867, and since 1874 he was certain no attempt had been made to alter it.

Dr. HACK TUKE said he was rather surprised at that, knowing the very strong feeling which had existed in Ireland for years.

Dr. CONOLLY NORMAN said there had been a strong feeling among asylum superintendents, but unfortunately they were a very small body.

Dr. HACK TUKE then read a paper "On a Recent Visit to Gheel." (See Original Articles.) In concluding his paper, Dr. Hack Tuke referred to the particulars given in the Lunacy Commissioners' Report of boarding-out of lunatics, and said that he should have much liked to obtain the number boarded-out with strangers in England. This, however, he had been unable to get, but he was informed at the Lunacy Office that the number boarded-out in that sense would be so small that the practice could hardly be said to exist in England.

Dr. SAVAGE said that he had spent three very memorable days at Gheel early in the spring. He arrived there about nine o'clock one evening, expecting to find a somewhat important station and town, and when he got there he found that the only porter at once closed the light, and left him with his portmanteau to find his way as best he could, and after much plunging through mud he managed to get to the little inn. He quite agreed with Dr. Tuke that with regard to the case of the boy referred to, who was spending his life in indolent insanity, it was very unsatisfactory. He got up at once, and had a meal with coffee. Soon after *table d'hôte* came on, and at this, on the second day, he said he would not have any meat, and asked for gateau, whereupon they brought him a huge plum cake. He then called for champagne, and between the two he made a very fair meal. In the evening he was very anxious to join Dr. Savage, who was introduced to the theatre, and to some

patients who were playing exceedingly well. One violinist played beautifully—who was a dement—-and had to be carefully looked after and taken out two or three times during the performance for fear an accident might happen. The boy was soon drinking beer with everyone. Certainly, there was liberty enough, but what possible good result could come from such treatment? He was certainly unfavourably impressed by that. The next day he was placed in the hands of a young Swiss and one of the guardians, who passed him on to other guardians. What most favourably impressed him was the freedom with which Dr. Peeters allowed him to go anywhere. The language spoken was perfectly incomprehensible to him, but he went into many of the cottages. It appeared that about every third house was a place where they sold beer. One day it happened to be a feast day, and he saw the patients sitting round fires. Dominoes and cards were being played by the guardians, but not by the patients, who were fed, but not amused. The guardians had become habituated to their presence from childhood. Indeed, the very result Dr. Tuke feared, would appear already to have been established. He saw a young peasant girl who was engaged to be married to a native, a confirmed epileptic. Here was a girl who had grown up in the neighbourhood who had no more dread of nervous disease than to be ready to join herself for life with such a man. Altogether he thought there were great dangers in the present mode of living, the estaminets being so frequent. He saw on the feast-day one or two people who appeared to be drunk, and in the evening the amount of beer consumed in the little theatre and elsewhere seemed to be excessive. He was certainly struck with the cleanliness of the patients. Many of them were demented, and of a class one would think would be wet and dirty; but he saw only one who was wet and dirty when he was there, and he saw them at all times. He was told, "Well, you know, it is so very much to the interest of the guardians to keep them clean, and they do keep them clean." He was also told that bed sores and such things were excessively rare. He did not think it was a place one would at all recommend. One or two imported patients whom he saw there were completely neglected, and he considered that the taking of patients away from their natural surroundings and sending them to a place like Gheel was not to be recommended. He must say, however, that on a fine day the flat lands round about Gheel, with the long meadows and the little dykes and the poplars, presented very striking lowland scenery indeed. He would warn visitors to Gheel to take with them some one who understood the trains, and could talk Flemish. He was put into the wrong train, and found out afterwards that he was going in the direction of Cologne instead of towards Antwerp, and that it was no use making any fuss about it as there was no train at all till the next day.

Dr. PRITCHARD DAVIES said he should like to express his full concurrence with everything which had been said by Dr. Tuke. He had read the pamphlet of Dr. Tucker, who had laid enormous stress upon the religious aspect, and had held it up to ridicule, which it did not quite deserve. The other visitors and himself had been received in the most kindly way by the church folks, who said that although they did not attach much importance to the religious ceremonies, many of the people did; and in the presence of this belief, would it not be wrong to cut away that system and deny it to the poor Belgians? Dr. Tucker had drawn a harrowing picture of the patients who were restrained in different postures. Their experience was directly at variance with what Dr. Tucker said. There could be no doubt that the worship and peregrinations at the shrine had at one time been very great. He went through the place, and noticed that the track, although in stone, was worn, and as it had always to be done on bended knees, it was clear there must have been an enormous number of people going through it. He agreed with Dr. Tuke that the statistics might be very misleading. To the ordinary mind, it seemed impossible to grasp the idea that with sixteen hundred lunatics at

large together, and roaming about at their own sweet will in darkness, there should be no more immorality than was represented. They were told that in a certain number of years there had been only a certain number of bastard children born; but if the evidence of patients was to be credited, the amount of immorality was greater than this indicated. Putting aside the evidence of an excitable patient, that of another could not be lightly passed over. This occurred to him as one of the gravest defects. In one of the other asylums in Belgium they found an English woman, who begged very hard to be allowed to go back. She was thoroughly well taken care of; in fact, some of the Belgian asylums compared favourably with the English asylums, but she complained that she was away from home, and wanted to see her friends. It certainly seemed to him that the most important thing they saw at Gheel was the facility of deporting away the unfortunate members of families—a facility which, if it were more generally known in England, would, he feared, be largely made use of.

The CHAIRMAN asked Dr. Tuke whether he learned any particulars as to the result on the population of Gheel of their contact with insanity which had been going on for some generations.

Dr. HACK TUKE said he found that the proportion of lunatics in the commune of Gheel to the population was rather less than in other districts of Belgium. The evidence, at any rate, was that the number of people who went insane in Gheel was not any larger than that of those who went insane in other parts of Belgium.

The CHAIRMAN remarked that it appeared from Dr. Tuke's account that the chief restraint on liberty in Gheel was the want of money, or, to coin a new term, "pecuniary restraint."

Dr. TUKE said there was no doubt a great deal of truth in that, although, of course, the patients got a little money by their work.

Dr. COBBOLD said that Dr. Tucker mentioned in his paper that mechanical restraint was made use of by the guardians, leather gloves, &c., being freely used, and if the patients resented it or complained they were removed to the asylum. He had listened very carefully to Dr. Tuke's paper, and did not hear him contradict a single fact in Dr. Tucker's paper. Dr. Pritchard Davies certainly did contradict Dr. Tucker's pamphlet to a certain point, but he did not think that the latter condemned Gheel on religious or superstitious grounds altogether. His condemnation of Gheel was more comprehensive. He (Dr. Cobbold) thought they might feel thankful that there was no such state of things in this country, and he hoped there never would be any such.

Dr. TUKE said that Dr. Tucker's objections were very strongly stated in regard to the condition of the houses. That did not strike them. In regard to the two idiots, there was at times a certain amount of restraint, such as cross bars on the chairs in which the patients sat, but they could not criticise that. Altogether, he thought the general impression produced on the mind by reading Dr. Tucker's paper would be more unfavourable than the impression he himself received on visiting Gheel, although, as he had said before, he did not come away feeling at all enthusiastic in regard to the system, or anxious to see it adopted on anything like so large a scale in England.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—SCOTCH MEETING.

A Quarterly Meeting of the Medico-Psychological Association was held in the Royal College of Physicians, Edinburgh, on Thursday, 5th November. Present: Dr. Rorie (chair), Drs. J. A. Campbell, Clark, Clouston, Ireland, Love, Mitchell, Ronaldson, Rutherford, and others.

Dr. R. B. MITCHELL exhibited microscopic preparations of diseased cerebral blood-vessels from two cases of general paralysis.

Dr. CLOUSTON showed an enormously-distended stomach, which was interesting from the circumstance that the patient had for some time before death

been fed by the stomach-tube; the fluid was retained in the stomach by the occlusion of the pyloric orifice by a cancerous mass. This condition was not discovered during life. The case resembled one of ascites, the more so as the liver was known to be affected.

The CHAIRMAN, in the absence of Dr. Urquhart, showed plans of proposed additions to Murray's Royal Asylum, in the form of two hospital wings, one for each sex. The plans were carefully reviewed by the meeting, and the comparative advantages of detached hospitals, separate villas, and wards partially detached, or connected to the main building by glass corridors, were discussed.

Dr. R. B. MITCHELL read extracts from a paper "On Syphilitic Insanity."

The CHAIRMAN complimented Dr. Mitchell on the great value of his paper, which he hoped would yet be published in its complete form. He considered that great interest attached to the connection between syphilis and insanity; and he had often been impressed with the resemblance between syphilitic insanity and general paralysis, a point on which he would like to hear the views of some of the members present.

Dr. CLOUSTON agreed with Dr. Rorie in considering Dr. Mitchell's paper a very important one. The statistics, especially, were very valuable. There was one thing very striking, viz., the number of the cases. If there were so many cases of syphilitic mental disease of an aggravated type in our asylums, might there not be mild cases where men who have had syphilis undergo some mental failure, or acquire some mental twist, not proceeding to insanity? Are there not a much larger number of cases of syphilitic psychosis than might at first sight be supposed? I can call to mind several cases of men in the prime of life who have failed in business; who, in fact, had become mildly demented, and where, in all probability, the origin was syphilitic. Not long ago I was consulted about a gentleman who, when apparently well, and doing a good business, had an attack of slight hemiplegia, but he went on occupying an important position in the business until a crisis came, and he broke down. He became confusedly delirious, or, rather, maniacal in a delirious way. I was inclined to give a good prognosis in the case, but I was wrong. He had difficulty in passing urine, and a catheter had to be used, which ended in his dying of blood-poisoning. There is another point suggested by Dr. Mitchell's paper, viz., the possibility of arresting syphilitic arteritis. This is usually a localized affection, certain sets of arteries being affected, and generally only certain portions of these. With regard to the interesting question which has been raised by the Chairman—the relations between syphilis and general paralysis—it has been averred by some that general paralysis is of syphilitic origin. This, however, is not borne out by clinical facts. There are, however, cases where we have to suspend our judgment, and try the effects of iodide of potassium. The only hopeful outlook for these cases is that they may be syphilitic. I think that there is no connection between syphilis and general paralysis. It may be that a general paralytic may have had syphilis, and that we may find general paralysis engrafted on a syphilitic brain. Some of the pathological appearances resemble each other, but the general diffused lesion which we find on the cerebral surface, and which is so characteristic of general paralysis, is not of syphilitic origin.

Dr. IRELAND thought that the connection between syphilis and insanity was a subject which had not yet been fully worked out. Twenty years ago it was thought that syphilis had very little to do with brain troubles. The nervous system was certainly more spared than any other, but still it was occasionally attacked. Many years ago, when in the Army in India, he saw numerous cases of syphilis, so severe sometimes as to cause death, but he never saw insanity result. Some cases, however, may have entered asylums afterwards. Syphilitic parentage he had rarely found to be a cause in cases of idiocy.

Dr. CAMPBELL and Dr. CLARK commented favourably on the paper.

It was resolved that the next meeting of the Northern section be held in Carlisle on the second Thursday in April.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—IRISH MEETING.

A Quarterly Meeting of the Medico-Psychological Association was held at the Royal College of Physicians, Dublin, on Thursday, November 29th, 1885. Present, W. H. Gurner, F.R.C.S.I., in the chair, Dr. Ashe, A. Patton, M.B., Dr. Merrick, T. Draper, M.B., J. Moloney, L.K.Q.C.P., E. M. Courtenay, M.B.

Dr. MOLONEY showed some interesting specimens of instruments of restraint formerly in use in Swift's Hospital.

Dr. PATTON read notes of two cases of insanity connected with injury of the recto-vesical septum during parturition. In one recovery resulted after severe hæmorrhage; in the other, after a prolonged condition of melancholia, the case became one of dementia, with masturbation and filthy habits, afterwards refusal of food, requiring forced alimentation, with delusions of grandeur resulting in chronic and hopeless insanity. (See "Cases.")

The CHAIRMAN considered that recovery seldom resulted when associated with habits of masturbation.

Dr. MERRICK pointed out how recovery had followed in Dr. Patton's first case after a severe hæmorrhage, and that oftentimes improvement resulted from some severe shock to the system.

Dr. COURTENAY said that in many cases the recovery of the patient was often immediately after a severe outbreak of boils.

Dr. ASHE gave some details of a case of *petit mal*.

The CHAIRMAN drew attention to the religious habits of epileptics.

Dr. MOLONEY related an interesting case of a clergyman who took bromide of potassium as part of his daily food for a considerable time to ward off epilepsy.

Dr. MERRICK stated that he only remembered one case of anæmic epilepsy in which recovery had taken place, that in the County Antrim a curious belief existed that pork was a cause of epilepsy, and that in his asylum the epileptics refused to eat pork.

Dr. COURTENAY read a paper on "The Diet Tables of English Asylums."

The following were elected members of the Association:—

Myles, William Zachary, L.F.P.S.Gls., Asst. Med. Officer Richmond Asylum.

O'Neil, William Daniel, L.K.Q.C.P.I., Ass. Med. Officer Richmond Asylum.

Gordon, William Spear, M.B., Ass. Med. Officer, District Asylum Mullingar.

Harvey, Crosbie Bagnall, L.A.H.Dub., Asst. Med. Officer District Asylum, Clonmel.

"AFTER CARE."

ADJOURNED MEETING, BETHLEM HOSPITAL, 29th OCTOBER, 1885.

Were present: Alfred J. Copeland, Esq., Treasurer of Bethlem Hospital, in the chair; Surgeon-General C. R. Francis, Dr. D. Hack Tuke, Dr. Norman Kerr, Dr. Cobbold (Earlswood Asylum), Dr. T. Clay Shaw, Hon. Treasurer of "After Care;" Rev. H. Hawkins, Hon. Secretary; Mrs. Ellis Cameron, Hon. Secretary Ladies' Committee; the Hon. Mrs. G. M. Glyn, Hon. Mrs. Pelham, Mrs. Pelham, and several other ladies.

The Hon. SECRETARY, in his report, referred to the death of the Earl of Shaftesbury, first President of the Association. Some incidents of his relation to it were referred to; the expression of his interest in the subject of "After Care" when first brought under his notice; his acceptance of the Presidency, and his presence as Chairman at four successive anniversaries; his opinion of the need of "After Care," and of a home for mental convalescents. The result of a sale of fancy articles by Mrs. H. Hawkins was announced, for which a sum of £19 2s 6d was forwarded to the treasurer's account at the Union Bank of London, Argyll Place.

Dr. SHAW read a statement of funds in hand or promised; referred to the boarding-out system advocated by Dr. Lockhart Robertson as one way of find-

ing accommodation for convalescents, and explained his estimate of the annual expense of a home at £300.

Dr. HACK TUKE said that he was not particularly fond of the Scotch system of boarding-out, but some of the objections which weighed with him adversely would certainly not apply to convalescent patients being placed in families. Boarding-out might, therefore, be worthy of consideration, seeing that a home involves such serious outlay, not for once only, but every year.

Dr. NORMAN KERR declared himself to be dead against the boarding-out system. The risk of relapse would be a serious difficulty. There was need of a home for convalescents, but he considered that the estimate of £300 per annum was insufficient. He suggested drawing-room meetings, and considered that a sum of £1,000 should be aimed at.

Surgeon-General C. R. FRANCIS spoke decidedly in favour of a home.

It was proposed by Dr. NORMAN KERR, and seconded by Surgeon-General FRANCIS, "That the Committee be authorised to take steps to raise funds for the equipment and subsequent conduct of the projected home by means of drawing-room meetings and otherwise; two funds to be opened: (1) one of donations for equipment; (2) the other of annual subscriptions."

Mrs ELLIS CAMERON referred to the movement of 1815 for the improvement of the condition of lunatics, and the corresponding effort to better the position of convalescents; to the progress of the Association since the formation of the Ladies' Committee; to the interest taken in the subject by the late Earl of Shaftesbury; to the want of a specific home; and to the reception she had given to applicants. She also proposed that sub-Committee meetings should be held at intervals of two or three months.

Proposed by Dr. NORMAN KERR, seconded by Dr. HACK TUKE, "That Lord Brabazon be requested to accept the office of President; that, failing Lord Brabazon, Mr. S. Morley be similarly invited," the Hon. Secretary to communicate the invitations.

The TREASURER, in assenting to the meeting of the Association at Bethlem (on 29th January), observed that reference should previously be made to Dr. Savage.

With thanks to the Chairman, the meeting separated.

CONGRESS OF PSYCHIATRY AND NEURO-PATHOLOGY AT ANTWERP.

We briefly noted in the last number of the *Journal* the assembling of an International Congress of Psychiatry and Neuro-Pathology, initiated by the *Société de Médecine Mentale de Belgique*, and presided over by M. Desguin, to whose admirable fairness and courtesy we bore witness. We propose now to give an abstract of the proceedings which will serve to indicate the principal subjects of deliberation. These proceedings are contained in a report of the Congress which has been issued by the secretaries, who notify their intention of presenting a more detailed statement at a subsequent time. Among our Original Articles appears one of the papers which was read at the Congress, for permission to publish which, we have to thank the author, as well as the Secretary of the Congress, M. Ingels. We hope to be able to present in a future number at least one more of the valuable papers which were read at the meetings of the Congress.

MONDAY. SEPTEMBER 7TH, 10 P.M.

M. DESGUIN opened the first meeting by making the following speech:—Gentlemen and dear Colleagues—The first magistrate of the city of Antwerp gave expression just now to the interest he takes in the work of the Congress which is about to commence; he also assured you of the cordial feeling that awaits you in our city, and bade you welcome in the name of the Administration of the Commune.

It is now my turn, as President of the Organizing Committee of this assembly, to welcome you on behalf of the Belgian Society of Mental Medicine. I say to you, therefore—to you especially, learned colleagues from other countries—we are proud to receive you, and we thank you for your response to our call; your knowledge and experience will illuminate our discussions, and render our debates fruitful. For our part we will strive to uphold the ancient fame of the city of Antwerp for hospitality; we extend to you the hand of friendship, desirous of being as agreeable to you as possible, and useful if we can.

I thank, too, the magistrates and jurists, and the medical men, who, forming no part of our Association, have come to meet with us, for their presence; together will we seek for the solution of the important problems on our programme, and if we do not attain to complete success, if the difficulties are beyond our strength, we will at least do all in our power to triumph over them.

We appreciate your presence the more, gentlemen, because in calling you to this assembly, the Society of Mental Medicine has, perhaps, acted rashly.

Still a young member of the family of scientific societies, and necessarily limited in its action by the restricted area within which it moves, our Society, though anxious to follow in the paths marked out for it by its elder brethren, can render profitable the discussion of the questions which it places before you only by calling upon your enlightened minds, and by relying on your authority.

Then, too, it counted on the attraction of the Universal Exhibition, which is daily bringing a crowd of strangers within our walls, adding to the interest of our gathering, and perhaps assuring us of the presence of some amongst you. If, then, we have committed the sin of pride, we hope you will be kind enough to accord to us the benefit of extenuating circumstances.

The Organizing Committee thought that, for profitable work to be done, it ought not to multiply the questions submitted for your examination. It has chosen two, which, from their general nature and international character, seem best adapted for discussion by an assembly composed, like ours, of cosmopolitan elements.

The first of these questions, "An Inquiry into the Bases of a good International System of Statistics of Insanity," forms the subject of a report by Professor Lefebvre, of the University of Louvain. This report, which has been distributed to you, has been discussed at length, and unanimously approved of, by the Society of Mental Medicine; you may therefore regard it as representative of the ideas of our Association. Satisfactory statistics of mental diseases, whence may be drawn rigorous conclusions with regard to pathogeny, etiology, termination, &c., can evidently be of value only if based on a good classification. Now it is well known what disagreement there is over the various classifications of mental diseases, however great may be the authority of those who have elaborated them. But if no one classification succeeds in rallying round it the various alienists of even that country in which it originated, the difficulty is increased when it is proposed to be made the basis of an international statistical system. The main point, at any rate at the outset, is to lay down some incontestable principles on which all may agree, and within the limits of which may be included comparable facts collected in different countries.

No doubt such statistics will be incomplete, if insanity be regarded from a general point of view; but they will be complete and exact on the various points which may have been adopted, and that result is attractive enough to merit being put to the test.

And, after all, as soon as the progress of psychological science permits, there will be nothing to prevent additions being made to the number of species on which statistics may bear. Such are the views which have inspired Professor Lefebvre, and led him to the conclusions which will be submitted to the Congress.

"The Relations between Criminality and Insanity" form the subject of the second question, on which M. Semal, medical superintendent of the lunatic asylum at Mons, has been instructed to draw up a report, which also is in members' hands. This report, gentlemen, the author expressly tells you in his

introduction, is a personal work. The view which he took of the task entrusted to him compelled him to state the most recent philosophical doctrines on human liberty and responsibility—doctrines which, far from being universally accepted, are, on the contrary, strenuously opposed by a great school of philosophy. They could not, therefore, be submitted to the deliberation of the Society of Mental Medicine, still less to its vote. Nor could they form the subject of your discussions, for these discussions would most certainly have been barren. But, whatever be the doctrines which we may uphold, one incontestable fact remains, viz., that insanity often leads to crime, and that crime is often a manifestation of insanity; in short, that crime and madness are frequently related. Are not delinquents and criminals, condemned as such, often shut up in prisons, who would be more suitably placed in a lunatic asylum? If it be urged that well-defined physical and moral symptoms often betray insanity even before the first manifestations of mental disturbance—and nobody doubts that it is so—are we not bound to inquire whether similar signs may not be met with in delinquents and criminals? An inquiry is then demanded, on parallel lines, in asylums and in prisons.

Such is the conclusion to which (without in any way prejudging its results) M. Semal comes. If you agree with him in recognising the need for these comparative researches, you will have to decide in what direction they should be conducted; you will draw up the scheme of this inquiry, and will find the means for making it fruitful by determining the way in which its elements are to be collected and co-ordinated.

I am not afraid, gentlemen, that any one in this assembly will be alarmed at the possible consequences of these inquiries; medical men are not used to recoil before a problem, however formidable it may appear at first sight; strong in conscience, we shall regard it calmly, and shall advance resolutely, with Science for our sure guide, towards our common goal, which is Truth.

The PRESIDENT then declared the session of the Congress of Mental Medicine open. After the election of officers (see Journal for October, 1885), and the transaction of some minor business, the meeting adjourned.

AFTERNOON MEETING.

M. GIRAUD, medical superintendent of the lunatic asylum at Fains, read on behalf of M. Foville, inspector-general of the department for the insane in Paris, who was absent, an article "On the Right of the Insane to appear before the Civil Tribunals to claim their Discharge."

Among laws relating to the insane, those of France and Belgium are distinguished by a common tendency which gives both of them a character of liberality such as would be sought in vain in other special legislations. By virtue of these laws every one placed in a lunatic asylum has the right of claiming his discharge before the civil tribunal, as often as he likes, and at any time. There are, however, points of difference between the practice of France and that of Belgium.

From the comparative study of the laws of the two countries, and discussion of those practical points in which differences exist, M. Foville thinks the following considerations may be deduced:—

(1) The right of claiming discharge should be allowed indifferently to all persons placed in asylums; consequently, there ought to be no exception in the case of minors and of persons declared incapable of managing their own affairs.

(2) Persons ought to be allowed to make their claim in as simple and inexpensive a way as possible; to wit, an ordinary letter addressed direct to the president of the tribunal, or to the *chef du parquet*, without the intervention of a solicitor.

(3) The persons responsible for the admission should be notified of the demand for discharge made by the patient, so that they may, if there be occasion, state their case.

(4) The right of making this claim should be free from any pecuniary liability.

(5) Decisions taken to the Council Chamber by the civil tribunals on the subject of the discharge of patients in an asylum ought not to be subject to appeal.

M. OUDART, inspector-general of the insane institutions of Belgium, read a paper on "The Colonisation of the Insane." The overcrowding which exists in the asylums of the kingdom, and the impossibility of meeting it by the incessant erection of new asylums, make the plan of establishing colonies undeniably opportune.

M. Oudart considered colonisation in three aspects: (1) The welfare of the patient; (2) the interest which should be taken in the question by the communes, the provinces, and the State; and (3) the advantages which the inhabitants of the commune in which a colony might be established would derive from this mode of assisting the insane.

Patients were benefited by the family life and the comparative liberty which colonisation secures for them. M. Oudart thought that one-third of the insane at present confined in the asylums of the kingdom, *i.e.*, 2,000 souls, might benefit by it.

From a pecuniary point of view, the saving effected by placing these patients in cottages would be more than £4,000. If the 2,000 insane had to be placed in new institutions it would cost more than £280,000.

As for the financial advantages which would be reaped by the inhabitants of the locality transformed into a colony—that their importance may be appreciated, it is enough to recall the fact that the accounts of the Colony of Gheel show an annual receipt of more than £28,000. In consequence of these humanitarian and economic considerations a second colony, Lierneux, has just been founded. There is another reason which called for the erection of a new colony. Gheel is a Flemish colony; and as the language, living, manners, and customs are not those of the Walloon people, Lierneux will be reserved for the Walloon insane.

M. Oudart next recounted various objections and hindrances it had been necessary to overcome before the erection of the new colony, of which he gave a short topographical description. The remarkable results already produced by this new organization augur well for the future of this method of colonisation.

Professor BENEDIKT, of Vienna, read a communication on "The Specific Effects of Static Electricity."

The eminent professor has resumed the use of static electricity, after having abandoned it for several years.

If it were true, as was formerly written, that static electricity had a direct salutary influence on the inflammatory processes of the auditory apparatus, it was expedient to try these experiments again with the new appliances at our disposal: inflammatory affections of the ear occasion cerebral disorders, on which static electricity exerts its influence by combating the disorders of the intracranial circulation. M. Benedikt has subjected these patients to static electricity, insulating them and applying the electro-static douche; this method of procedure caused, in a considerable number of cases, the disappearance of cerebral disorders following affections of the ear; after a certain number of applications, the result, which was at first only transient, became permanent.

A curious observation confirmed his opinion. A lady, under treatment by static electricity for a sort of neuralgia of the legs, lost her memory for several days in succession, through the use of the electric douche.

In another case, one of amnesia, the electro-static douche had at first a transient success; but after its repeated use recovery was lasting.

Epileptics may benefit by the use of the electro-static douche; Dr. Benedikt gave instances of this.

M. MAGNAN desired some additional information about the patients treated by M. Benedikt. He was utterly unable to express his surprise at hearing of the positive cure of a paralytic.

M. BENEDIKT did not claim to have cured the patient. He had alleviated the symptoms ; he had applied a calumative ; but the patient remained paralysed. But, for patients suffering from that sort of psychosis which accompanies inflammatory conditions of the ear, there is no remedy more certain than the electric douche.

M. MIERZEJEWSKI had observed that this method, so far from benefiting epileptics, brought on their attacks.

M. BENEDIKT had, it was true, treated only one epileptic successfully. He, too, was of the opinion that this treatment was not suitable for general use in epileptics.

M. VERRIEST, professor in the University of Louvain, made a communication on a particular class of paralyses, which he christens "Paralyses through Unconsciousness." The patient, whose pathological condition he described, was paralysed in the right hand as soon as she averted her eyes from it. When she again looked at her hand its power of motion instantly returned, and it executed the most complex and delicate movements. This form of paralysis, of which two or three instances are recorded in the annals of science, was analysed by M. Verriest in the light of its physiological mechanism.

From inductions based on the genesis of these phenomena, M. Verriest was led to conclude that there was a morbid torpor of those cerebral regions on which the image of the paralysed arm was projected, a torpor dissipated under the influence of stimuli coming from the optic centres by way of the associated fibres.

Starting from this hypothesis, it occurred to him that stimuli coming along other associated tracks might perhaps be of equal service in removing the paralysis. He stated that, in fact, motility returned to the affected limb equally well through the sense of touch ; it was enough to make the left hand feel the paralysed right hand, in order to restore motion to the latter. The same result was obtained by means of the faradic brush applied with intensity sufficient to cause pain, and therefore consciousness—the notion of the existence of the paralysed hand.

In M. Verriest's opinion, a good number of paralyses in hysterical subjects belong to this category of "paralyses through unconsciousness," with this difference, that the cerebral torpor is not dissipated under the influence of stimuli coming along associated fibres.

Possibly there is a similar production of "paralyses through unconsciousness" in general paralysis, but depending in this case on anatomical changes.

M. GARNIER, inspector of the asylums of the Seine department, and physician of the special infirmary for the insane in connection with the *préfecture de police*, read a "Medico-legal Report on a Case of Morphinism, with hystero-epileptic attacks resulting from abstinence from the habitual dose of the drug."

H., female, had for several years been addicted to the use of subcutaneous injections of morphia, more because of an incessant need for allaying attacks of pain than through any morbid craving for the narcotic ; she had not fallen into that condition of marasmus, of physical and intellectual alteration, which result therefrom. She could not be regarded as irresponsible for the crime she had just committed. But she was seized with hystero-epileptic attacks, developed by the abrupt deprivation of her habitual dose of morphia.

M. Garnier proceeded to make some observations on the effects of morphia. Insanity directly caused by injections of morphia is comparatively rare. There is no clearly defined morphia-madness, such as has been spoken of, to compare with alcoholic insanity. But it is impossible to reject absolutely the morphinic psychosis described by Laehr and Fadler ; its existence must be admitted in those cases which display an impulsive tendency, a neuropathic or hereditary morbid craving.

Dr. BROSIUS, superintendent and proprietor of the private asylums at Ben-

dorf and Sayn, made some observations on "The Use of Alcohol in the Treatment of Mental Diseases." The effects of alcohol are many, and vary according to individual constitution, and the dose and chemical composition of the alcohol used. Diluted, and in small doses, it is a stomachic, a cardiac and circulatory excitant, and a brain-stimulant. It facilitates ideation, and induces a feeling of comfort. This cerebral stimulation is followed by sleep, the duration of which depends on the dose of alcohol. Alcohol also dilates the cutaneous vessels and increases perspiration, in this way also promoting rest. In large doses and undiluted, it produces contrary results, leading to complete paralysis of body and mind. It improves general nutrition, as an indirect nutritive agent, because it promotes digestion, and is burnt in the organism instead of albumen. It diminishes the formation of urea, and by retarding the breaking down of tissue it favours *embonpoint*. In certain diseases, if food is badly digested or insufficient, alcohol diluted is an excellent digestive remedy. From his own personal observations, made during a practice of thirty years, Dr. Brosius was led to the conclusion that alcohol, diluted and in small doses, in the shape of a good Rhine wine, Bordeaux, or sherry, is never injurious to merely neurotic or insane patients. In many cases of mental disturbance with restlessness and insomnia, it is sedative and hypnotic. Some glasses of sherry at night, or half a litre of Rudesheimer or some other good wine, or beer, immediately cause quiet or sleep, even in cases where morphia was powerless. It benefits dyspeptic melancholiacs, and all insane patients who are losing flesh in consequence of defective digestion. It should be given to paralytics even when excited. It is the best alternative to bromide and morphia, to which remedies the organism tends to become habituated. Dr. Brosius asked how medical men who use paraldehyde, the formula of which is C_5H_4O , could refuse to give alcohol, when its formula is almost the same, viz., C_2H_5O . He had, it was true, cured patients without the use of either alcohol or beer; time being still the great remedy in our specialty.

M. MAGNAN was surprised to hear alcohol spoken of as a good remedy in insanity—in melancholia. If M. Brosius referred only to vinic alcohol, he would agree with him. In the asylums of the department of the Seine, more wine was given than bromide. But the alcohol of rum and cognac is an amylic alcohol, which is injurious and poisonous. He suggested that, in order to avoid confusion, M. Brosius should alter the title of his communication to "The Use of Wine and Tonics in Mental Diseases."

Dr. GARNIER, of Paris, fully agreed with what M. Magnan had just said.

M. BROSIUS consented to the modification suggested. It had been his intention to speak of the use of alcohol in the form of wine or beer.

Dr. REX, physician at Ville-Evrard, read a "Note on General Paralysis in Females, and on Hysteria in Females suffering from General Paralysis." Dr. Rex stated that, out of 30 women suffering from general paralysis, whose histories he had collected, seven had had attacks of hysteria at a longer or shorter interval before the onset of the cerebral disease. The hysterical attacks varied in duration, and were characterised by disorderly movements, shedding of tears, and occasionally contractures of the extremities. All the seven patients had hereditary antecedents, neurotic or congestive. Menstruation had, as usual, been frequently irregular. Among intellectual disturbances at the onset of the disease, there have been observed enfeeblement of the intellectual faculties, especially of memory, or some change in the character, or unconscious acts. Insanity develops insidiously; it is often melancholia with suicidal ideas; in two cases it was erotic and accompanied by maniacal excitement. Only one out of the seven cases had had hysterical attacks during the course of the general paralysis. All had presented the typical symptoms of the cerebral affection. One patient had had a remission, two had died, four were still under observation. To sum up, the following conclusions may be drawn from the facts observed:—"General paralysis, developing in women suffering from hysteria

is by no means exceptional; most frequently, in these cases, the hysterical manifestations diminish or disappear; the insanity sometimes takes on a special character, which should give rise to the suspicion of neurotic antecedents. Finally, the course and duration of the general paralysis present nothing unusual."

M. CLOSSET, of Liège, read a paper on "Acute Mania and its Treatment based on Pathogeny." Malnutrition of the nerve-cells usually leads to their increased activity, whence results a period of excitement. Malnutrition is succeeded by cellular degeneration; to this stage corresponds the occurrence of dementia, anæsthesia, and paralysis. Attacks of mania must then be treated by agents capable of rousing the vitality of the nerve-elements, by reflex stimulants in preference to reflex sedatives.

Dr. HACK TUKE next made some observations on "Sleep-walking." He had had distributed among the members of the Congress a set of questions similar to those which had been published by the British Medical Association, having for its object the facilitation of inquiry into this affection, which he wished to see henceforth ranking among the neuroses. He inquired into the relations existing between this and other diseases of the nervous system, especially epilepsy, chorea, and mental disease. He asked for the assistance of his fellow-members to define the symptomatology of this affection, and concluded by relating a case of spontaneous somnambulism which had lasted for three days without intermission. If the patient were roused he fell into a condition of almost complete catalepsy; there was also complete analgesia, and external stimuli had not the least effect on the organs of the senses. The knee-reflexes were exaggerated, the eyelids closed, the eyeballs turned upwards and outwards. When pushed forwards he kept on running till he came to some obstacle. This condition of somnambulism was obstinate; only a few moments after the patient was aroused he fell off again.

TUESDAY, SEPTEMBER 8TH, 10 A.M.

The meeting entered upon the discussion of M. Lefebvre's report on the "Inquiry into the Bases of a good International System of Statistics of Insanity."

M. LEFEBVRE, professor in the University of Louvain, after some observations on the end aimed at by the Belgian Society of Mental Medicine, said that, though the question on the programme was one of considerable difficulty, its solution would be very much facilitated if alienist physicians could agree upon a classification. This was the preliminary and indispensable condition of a good statistical system. M. Lefebvre demonstrated the possibility of forming some great groups of morbid types, and proved that most of the systems of classification hitherto proposed mentioned these groups. These types were idiocy, cretinism, general paralysis, dementia, toxic forms of insanity, mania, melancholia, and circular insanity. It was not M. Lefebvre's desire to impose the adoption of these types on the Congress, but he hoped that this important question would be thoroughly studied. By grouping the total numbers around these types, we should succeed in collecting, for the future, interesting elements for an international statistical system, especially on the following points:—

(1) *The number of insane in a given area, preferably in an entire country, such as France, England, &c.* At the same time, statistical tables prepared for a single locality, or even one particular establishment, would not be without their value.

(2) *The causes of insanity in general, and, as far as possible, of its various species.*

(3) *The duration of the disease.*

(4) *Its termination, by cure or otherwise.*

(5) *Its mortality.*

Dr. GUTTSTADT, of Berlin, suggested that the Congress should first decide whether statistics should include only the insane in asylums, or the whole number of insane. The results obtained in these inquiries were modified by the particular method employed. German physicians formerly had recourse to a classification similar to that mentioned in M. Lefebvre's report; but they have since adopted a much simpler system, the results of which are decidedly more trustworthy and constant. These inquiries had proved that in Germany there were 24 insane in 10,000 inhabitants, or 1 in 440. They also facilitated the calculation of the number of asylums necessary in each country. In the list of questions on which these inquiries were based, the following types of mental disease were distinguished:

- (a) Uncomplicated insanity.
- (b) General paralysis of the insane.
- (c) Insanity complicated with epilepsy or hystero-epilepsy.
- (d) Congenital imbecility, idiocy, cretinism.
- (e) Mania a potu.
- (f) Non-insane patients under observation.

Professor LEFEBVRE admitted the justice of M. Guttstadt's remarks. He thought it was advisable to separate statistical inquiries made on the insane in asylums from those on lunatics living at home. As to the difference between the two categories of types of insanity suggested by M. Guttstadt and himself, it was inconsiderable.

Dr. RAMAER, inspector-general of the lunatic asylums of Holland, rose to repeat what he had already said at a meeting of the Belgian Society of Mental Medicine, on the difficulty met with in the first part of the question—"The Classification of Mental Diseases." He laid stress on the fact that it was advisable to choose, as a basis of classification, as limited a number of types as possible. Many so-called types were only varieties or successive stages of one and the same form. Mania, for instance, may supervene in all forms of insanity; and almost all end in dementia. He thought, from the way in which Professor Lefebvre had treated the question, that there would be a prospect of attaining the end aimed at, if the Congress would accept his proposition "to appoint an International Commission to deliberate on the formation of a classification of mental diseases, forming the basis of all future statistics in the domain of psychology."

Dr. HACK TUKE, of London, reminded the members of the Congress that some years ago, the Medico-Psychological Association had drawn up a complete series of tables for the preparation of statistics. This had been extremely successful, and at the present time most of the English alienist physicians made use of it in preparing their statistical tables. He therefore, naturally, supported Dr. Ramaer's proposition, and recommended to the attention of the Congress the set of tables to which he had referred.

Dr. MOREL, of Ghent, said that the Secretary of the Belgian Society of Mental Medicine had published a translation of these tables in the Society's Bulletin, in 1882. He read the titles of the various tables.

Dr. CHRISTIAN, physician to the National Institution at Charenton, thought the inquiry must be limited to lunatics in asylums. It was impossible to get correct information about those not in asylums. The lunatic's relations were too much in the habit of dissimulation regarding his illness; and, if they could manage it, they sent him away, and spoke of his mental affection as a mere nervous malady. Regarding the probable cause of insanity, the public are not able to supply physicians with information of any value; often, indeed, notwithstanding the best information, the ætiology remains unknown. Again, the patient frequently appears to his family, and the public, to be cured, when he is not so at all, from a medical point of view. Thence arises a great difficulty in the way of a good international system of statistics of insanity. M. Christian supported the classification advocated by M. Guttstadt, on account of its great simplicity.

Dr. SEMAL, of Mous, remarked that hereditary insanity, which was a well-

defined morbid entity, had not been mentioned by M. Lefebvre. He supported M. Ramaer's proposition to appoint an International Commission; he, too, thought the inquiry should be limited to lunatics in asylums.

Dr. MAGNAN, of Paris, made some remarks on hereditary insanity, and thought that intermittent and chronic mania should be placed beside it, as types of psychoses.

President DESGUIN having asked M. Ramaer to formulate his proposition,

M. SCHLEICHER opposed the remitting of the questions on the programme to an International Commission. He believed it was possible at once to define some fundamental types on which all were agreed. The Society of Mental Medicine ought not to postpone till the Greek Calends a question on the consideration of which it had entered, and which it was able to settle.

Professor LEFEBVRE did not think we should wait for science to become perfect before we undertook an inquiry which might be commenced at once. Statistics would always be defective in every branch of human knowledge. He nevertheless supported M. Ramaer's proposition.

The Congress decided to proceed to the nomination of an International Commission, empowered to prepare a classification of mental diseases. The members appointed on this Commission were Drs. Hack Tuke for England, Guttstadt for Germany, Benedikt for Austria, Magnan for France, Steenberg for Norway and Sweden, Mierzejewski for Russia, Ramaer for Holland, Sola for South America, Clark Bell for the United States, Professor Wille (of Basle) for Switzerland, Professor Andrea Verga, senator (of Milan), for Italy. The Belgian Society of Mental Medicine would subsequently appoint representatives for those countries which had not sent delegates to the Congress.

The members of the Congress promised to communicate with the Psychological Societies of their respective countries, and to do all in their power to aid the Society of Mental Medicine to attain the end in view.

TUESDAY, SEPTEMBER 8TH, 3 P.M.

The PRESIDENT announced to the meeting that he had just received the sad intelligence of Dr. Lunier's death. He was sure he expressed the feeling of the entire assembly when he said that the loss of this eminent man would be deeply felt.

A letter of condolence in the name of the Congress was sent to Madame Lunier.

M. RICHARD BODDAERT, professor in the University of Ghent, gave an account of a new process which he had discovered in the course of his investigations on *cerebral softening*. It consists of the introduction into the vascular system, and more especially the arterial system, of liquids having the property of coagulating the albumen of the blood, or holding in suspension minute solid particles; this is done in such a way, by momentarily interrupting the circulation and then re-establishing it under normal conditions, as to determine the progress of coagula or foreign bodies just as in the ordinary mechanism of embolism.

M. Boddaert had caused facial paralysis in animals by the injection of a small quantity of alcohol into the common carotid; the paralysis was on the same side as the injection.

He showed three rabbits, two with facial paralysis, the third exhibiting the phenomena of paresis of the left fore-leg, following the penetration of solid particles into the left internal carotid, the external carotid of the same side having been closed for a brief interval.

Dr. VERRIEST, professor in the University of Louvain, showed a "patient with double consciousness." The patient was brought into the room in the *second state*, which is the usual one. In this state she was bright and lively, and expressed herself with exceptional facility in clear and well-chosen language. On

the mere *order* being given by M. Verriest, she fell into a sort of cataleptic condition, from which she awoke after a minute or two in a new state of consciousness—the *first state*. On opening her eyes, she was astonished and confused to find herself among so many people; she tried to slip away, and hid her face and eyes. In this new state she, like Dr. Azam's patient, was more serious and melancholy. She had no recollection of anything that had taken place while she was in the "second state," nor did she recognise any one unless she had previously seen him in the same "first state." She did not know where she was, how she came to be in that room, how or when she had left her native village, &c. In the "first state" she was dumb, but communicated with facility in writing; her writing did not differ from that in the "second state." In the "first state" she could drink, but could not swallow any solid food; in the "second state" the reverse was the case.

The "first state" lasted not more than 15 or 20 minutes, at the end of which the patient fell asleep *spontaneously*, subsequently awaking in the "second state." In this state she then remained indefinitely, until in obedience to *order*—never spontaneously—she returned to the "first state." Only five or six persons had this power over her; the commands of all others were ineffectual.

By means of hypnotic passes, the patient was thrown into a *third state*, differing from the ordinary hypnotic condition in this, that the patient retained her intelligence and her integrity of judgment completely, and that no suggestion had any effect on her.

On the hypnotic influence being removed, she invariably returned to the "second state," and had no recollection whatever of the pseudo-hypnotic third state. In the first state she had no more recollection of the third state than of the second.

Thus she could be made to pass successively, and at will, through three different states of consciousness, in each of which she displayed a clear and well-balanced intelligence. "In such a case as this," asked M. Verriest, "what becomes of Luys' hypothesis of the functional alternation of the two cerebral hemispheres?"

Dr. CHRISTIAN, physician to the Charenton Asylum, read a paper "On the so-called Fragility of the Bones in General Paralytics." (See Original Articles.)

Dr. B. INGELS, of the Hospice-Guislain at Ghent, confirmed Dr. Christian's observations on every point. During 30 years' practice in an establishment containing 500 patients, he had only seen three cases of fractured ribs, none of which were in paralytics; they were satisfactorily accounted for as the result of external violence.

Dr. MARIQUE, of Brussels, next made a communication on "Cerebral Localisation." He recapitulated the various proofs which have established the existence of cortical motor regions: experimental proofs by *galvanic excitation* (Fritz and Hitzig) and *faradic* (Ferrier), of the existence of excitable and non-excitable regions; by *destruction* or enucleation of a portion of the cerebral cortex, giving rise to various paralyses: by *pathological observations*, demonstrating the existence in man of motor disorders (epilepsy and paralysis) depending on certain lesions of the cerebral cortex.

M. Marique gave a brief description of the brain of the dog. In this animal the different cortico-motor centres are collected in a well-defined region, the sigmoid gyrus, the cells in which are attached to those of other parts of the cortex by associated fibres running in three directions. In different experiments, M. Marique completely enucleated the gyrus, or divided the three sets of fibres (in both these cases the result was the same), or divided one or other of these three sets. He came to the conclusion that these motor centres do not possess spontaneous activity, but that their activity is the result of numerous excitations coming from neighbouring so-called sensory regions, along associated fibres. It followed that voluntary acts (so-called) were only ordinary

reflexes, and that the reflex act was the general law of the nervous system. This physiological fact was one of the greatest importance, especially in its bearing on the question of responsibility, and the relations between insanity and crime.

Dr. Marique then laid on the table his work, entitled, "Experimental Researches on the Functional Mechanism of the Psycho-motor Centres of the Brain."

Professor BENEDIKT remarked that, however interesting and well-performed such experiments might be, any one who made use of them in order to raise the question of responsibility was very likely to fall into error. He was surprised to hear psycho-motor centres still spoken of as existing on the surface of the brain; Hitzig had proved that there were none. Paralysis caused by mutilation of these centres was only a result of the shock of the operation, and was not permanent. It was in a sub-cortical centre that conceptions were concentrated, and no one knew what were the relations existing between the superficial centres and those at a greater depth.

Dr. MARIQUE observed that if paralysis caused by mutilation of psycho-motor centres disappeared, it was owing to some compensatory arrangement. This had been proved by experiment. He regarded the motor centres as thoroughfares; they were the points of confluence of all the sensory paths in the brain. If paralysis caused in this way were to be attributed to shock, how was it that a section made a little further away did not cause paralysis?

Professor BENEDIKT did not wish to discuss M. Marique's experiments. He was only anxious that no premature conclusions should be adopted.

M. INGELS, superintendent physician of the Hospice-Guislain at Ghent, communicated some clinical observations on "The Relations between Epilepsy and Idiocy." These observations were based on the study of the children in the special section at the Hospice-Guislain. Out of 79 children then in the hospital, 25 were epileptic; out of 398 children who had been received as patients between the opening of the hospital in 1857 and August, 1885, there were 125 epileptics, or about one-third. Epileptic idiots and imbeciles were divisible into two classes; the first consisting of those in whom epilepsy and idiocy were both congenital; the second, of those in whom epilepsy had caused a sort of premature dementia. Epilepsy did not always exert the same influence on intellectual degradation; its action was sometimes abrupt and rapid, sometimes slow and gradual. Occasionally there was a period of arrest, extending over some years. It was these very children who seemed to derive such profit from the education given them. M. Ingels had been too busy with arrangements for the Congress to find time for grouping and interpreting these practical facts in a suitable way; it would be useless to weary the Congress with a monotonous reading of mere details, but he hoped that their publication would be authorised *in extenso* in the report of the proceedings of the Congress.

WEDNESDAY, SEPTEMBER 9TH, 10 A.M.

M. SEMAL entered on the consideration of his report on "The Relations between Crime and Insanity," which had been distributed among the members of the Congress. In studying the relation between crime and insanity, it had not been his purpose to create particular varieties of the species *homo*, and to admit the existence of a normal type, an insane type, or a criminal type. Nor did he wish utterly to overturn the prevailing views regarding criminality and the penal law. It was generally agreed that there were points of undeniable resemblance between certain criminals and certain classes of insane. He desired that that should be done in the case of criminals which had been done for lunatics, and that the question should be asked whether, in a case in which there seemed to be so much perversity, there might not be reason to admit the existence of disease. He therefore proposed that the Congress should declare that the necessity for holding an inquiry in prisons, on the physical, moral, and

mental condition of certain classes of criminals, had been proved by clinical, pathological, and anatomical facts.

Professor BENEDIKT discussed the subject of criminality at considerable length; he put on one side the theological aspect, and only took into account anatomical and physiological facts. He thus arrived at the following conclusions:—

(1.) Nothing justifies, or demonstrates the utility of the indiscriminate mixture of professional criminals with lunatics.

(2.) The psychical qualities of professional criminals are very limited; it follows that their minds are ill-balanced, and that the superiority of one of their normal qualities is injurious, because they have few (if any) compensating qualities.

(3.) The experience that all repression and all education fail to correct a certain number of persons, proves that these so-called incorrigible cases are really diathetic, either born so or have become so in early infancy.

(4.) The decisions of justice will be more just and more efficacious if, for the future, magistrates give more consideration to the question of responsibility and punishment as a philosophical hypothesis; on one hand, the question of an individual dangerous to order and to the institutions of society as well as to his own intellectual, moral, and material progress; on the other hand, the question of how far such an individual is capable of improvement, or whether recourse should be had to special precautions to prevent him from doing harm.

(5.) A series of accidental crimes connects the psychology of criminality with normal psychology.

(6.) If crimes are committed in a state of disease or of intoxication, they should still be classed among accidental crimes. Such a criminal is a pathological case, and should be judged as such; he might even be classed with epileptics or with lunatics suffering from some pathological process.

(7.) Other crimes, especially a large number of murders, are committed under the influence of marked degeneration, either congenital or acquired in early infancy. This degeneration arrests the development of that moral and intellectual nature which should preserve psychological equilibrium in critical situations. Criminals of this sort ought also to be classed with epileptics and lunatics, admitting an epileptic or insane diathesis.

(8.) Criminals should be divided into four classes: the first including those individuals who, once typical, have become criminals by accident; the second, ordinary diathetic cases; the third, insane criminals; and the fourth, degenerated diathetic cases.

Criminals should be judged and treated according to the results furnished by descriptive psychology. Science requires that each case be studied as regards its physiological mechanism; it is on science that the duty devolves of considering what is the treatment best adapted to each case. When science has accurate data to go upon, public opinion, and consequently legislation, will follow it. That this end may be attained, the academic education of magistrates and lawyers must be reformed. Their education at present might be compared to that of medical men before clinical hospitals were established, when the spirit of observation was almost entirely wanting. Dr. Benedikt did not deny that there were some magistrates who had an exact knowledge of criminal psychology; but unfortunately they only acquired it after long experience. He proposed that the Congress should resolve that it was desirable to establish in prisons (and especially in Antwerp, where there was a university) criminal clinics—i.e., practical courses for the study of criminal psychology.

Dr. WARNOTS, prosecutor to the University of Brussels, read a work in which he contrasted alienist with anthropological criminalists who plead for the irresponsibility of certain delinquents, but not their insanity. His work was essentially based on the views of Lombroso, Maudsley, &c., who admitted the existence of a distinct class of persons predestined to crime, and sure to become criminals "*by profession*," because their physical constitution is of a low

type, and they are either uneducated, imperfectly educated, or else incapable of being educated by reason of the unfavourable conditions in which they live.

Dr. SEMAL readily granted that anthropological studies might aid in the attainment of the end at which he aimed. Still, he had not wished to absolve the criminal of responsibility; he maintained that there was another class of criminals besides that which M. Warnots had described. He returned to his subject, the institution of an inquiry comprehending at one and the same time anthropological study, and also—the one is the consequence of the other—the study of the moral sense, of the mental condition of the criminal. M. Semal pointed out an instance of divergence between himself and M. Warnots. Degenerated patients and insane patients could not be confounded together. Hereditary insane are degenerated individuals who have displayed from infancy the character which later on becomes permanent.

Dr. HACK TUKE pointed out that M. Semal appeared, in his work, to deny free-will without denying the possibility of criminal responsibility. To deny the existence of free-will was tantamount to the denial of all moral responsibility; and, admitting this principle, the alienist physician found his occupation gone. There existed a definite relation between the mental condition and the cerebral organization of every man; but if this relation existed in the case of criminals, allowance ought also to be made for surrounding circumstances, education, religious feeling, &c. Dr. Tuke supported M. Semal's opinion that, even if certain criminals were insane, others were not, and should be held responsible; they would have acted differently if they had made use of their freedom of will.

Dr. VAN ANDEL, of Zutphen, thought the question had better be abandoned to jurisprudence. He declared himself a dualist, *i.e.*, a believer in the intimate union of soul and body to constitute the human being. He did not agree with M. Semal that scaphocephaly predisposed to insanity, and mentioned in support of his view, that Minchin, Barnard Davis, Calori, and others had met with scaphocephalic men of superior intelligence.

Dr. SEMAL mentioned a case of scaphocephaly in a lunatic; but he disclaimed the view attributed to him by M. Van Ansel, and declared that in his opinion scaphocephaly did not necessarily predispose to insanity.

Dr. HEGER, professor in the University of Brussels, stated that the most ardent partisans of modern anthropology did not believe that cranial or other deformities were connected with any particular form of insanity, or necessarily involved the development of insanity. In support of this he quoted his own researches on the crania of murderers executed in Belgium, and the authority of Professor Benedikt. There was no special form of cranium to associate with criminality; but it was imperative to study the physical and moral characteristics of criminals.

Dr. HOUZÉ, of Brussels, informed the meeting that the Anthropological Society had published a list of questions on this subject.

Dr. GOFFIN, of Brussels, said that M. Semal's work was on lines similar to those followed by the best modern thought in craniology, physiology, and psychology; it extended judiciously M. Magnan's studies on sexual perversion. He accepted heredity as one of the chief factors of criminality, but still he thought that it was possible to become criminal without the operation of this cause. This distinction was required from the point of view of psychology and sociology, to maintain the integrity of the laws of the Penal Code, and the rights of society. In M. Goffin's opinion, those who became criminals very often owed their condition to vicious education.

After some further remarks from Drs. Benedikt, Semal, Heger, Mierzejewski, Houzé, Garnier, Warnots, &c., the Assembly agreed to the following resolutions:—

The Congress, believing that the utility of an inquiry into the moral and physical condition of criminals has been demonstrated by anatomical, physiological, and clinical facts, expresses the wish:

(1) That the public authorities will support the continuation of the inquiry undertaken under the auspices of the Belgian Society of Mental Medicine.

(2) That a commission, including representatives of the magistracy, the higher penitentiary administration, and the medical element, be empowered to organize this inquiry, having for its objects:—

(a) Accused persons suspected of being insane.

(b) Persons who, being admittedly insane, have committed any crime whatsoever.

(c) Great criminals, and old offenders.

(d) Prisoners who during their imprisonment are found to be insane.

On the proposition of Professor BENEDIKT, the Congress expressed the wish that criminal clinics might be established.

The PRESIDENT, in closing the Congress, thanked the foreign savants for their attendance. He gave a summary of the results of the discussions, and invited the members to take part in the various excursions.

M. BENEDIKT, on behalf of the foreign members, thanked the Organising Committee of the Congress for the trouble they had taken. "We leave Belgium," he added, "convinced that every country which possesses a medical body like that which we have met here may consider itself fortunate."

BELGIAN ASYLUMS.

We have already in another section of the Journal related at some length our experience at Gheel, which constitutes for most mental physicians visiting Belgium the main object of interest.

Of the former, we may, however, say that there is much in their management and condition which reflects credit on those who are in charge. Several exist, no doubt, which from their age, the character of their government, and their locality, call for reform and adaptation to modern requirements. At Antwerp itself, the asylum of St. Roch is quite behind the times, and no one disputes that a new asylum ought to be erected outside the town. A praiseworthy attempt is made to employ the patients within the narrow limit which the building affords.

At Bruges there is room for improvement in the asylums, but it should be mentioned to the credit of the Hospice Saint Dominique that there is not only a very fine garden connected with it in the town, but some miles distant a farm to which patients are conveyed daily to work. There is also one associated with the Hospice Saint Julien. At Saint Dominique, the Director, M. Soleil, is active and humane, and the asylum is visited by Dr. Valeke, who obligingly took us to see it. To the Visiting Physicians to Saint Julien, Drs. F. Van den Abeele and Moulaert, we are indebted for facilities of visitation.

At Mons, the asylum superintended by the energetic and accomplished physician, M. Semal, was inspected with interest, and every facility afforded for seeing the whole establishment. Here, as in some other Belgian asylums, we might be allowed to doubt whether the influence acquired by the "Sisters" is not greater than it should be, although no doubt less at Mons than in those institutions where there is no resident medical authority. Here, as elsewhere, the contrast is somewhat striking between Belgian and English practice in the matter of non-restraint to which M. Semal has not yet become a convert. The accommodation provided for many of the higher class patients was exceedingly good in this asylum, and the charges would in England be considered very moderate.

M. Lentz superintends with much ability the new asylum at Tournai which has been built at great expense, and with careful consideration in regard to construction. An excellent model of it, as well as of a seclusion room prior and subsequent to 1850, with its unhappy occupant, was exhibited at the Exposition at Antwerp. The asylum at Tournai extorts from the visitor scarcely anything but praise, and if the Belgian authorities are to be congratulated on the care and expenditure lavished upon the building, they are still more so for their choice of so excellent an administrator as M. Lentz. Were we to indulge in any criticism, it would be in a mere point of detail—the arrangement adopted in regard to the

closing of the ponderous metal shutters of the seclusion rooms by an apparatus outside in such a manner as can hardly fail to terrify by its unearthly noise the inhabitant of the cell, who would be only too likely to believe himself located in certain regions from which the asylum in other respects is as far as possible removed.

At Ghent, the Hospice-Guislain recalls a great mental physician of whom Belgium is justly proud, and whom those connected with the insane in other countries no less esteem for his writings and for the practical work done by him at this institution where M. Ingels is his worthy successor. We are glad to know that the project of erecting a statue to Guislain is progressing, and will be probably carried into effect next summer. At this institution we were particularly pleased with the amount of work done in the workshops, and especially at the loom. The school for idiots is admirable. One of them, aged 7, presented a remarkable example of microcephalus, but displayed great agility and a certain kind of intelligence. The dimensions of the head were kindly taken for us at the time by M. Jules Morel, of Ghent, to whom members of the Congress were so greatly indebted for his unfailing help and courtesy.

The institution for the insane at Cortenberghe, near Brussels, called Hospice Saint Joseph, was visited. It is under the charge of the same religious order—*Sœurs de la Miséricorde de Jésus*—as St. Julien at Bruges and Saint George's Retreat, Burgess Hill. *Sœur Ambroisine* showed us over the institution with great courtesy. The cleanliness of the beds and rooms throughout the establishment, not excluding those for the dirty patients, was most marked, and reflected great credit upon those responsible for their condition, especially as the visit made one Sunday afternoon was totally unexpected. No patient was in seclusion, but many were sitting on benches in large rooms with their arms confined by long sleeves fastened behind in the usual way.

Our visits to the Belgian asylums afforded us much interest, and we must here acknowledge the courtesy and hospitality uniformly extended to us by those in charge. The latter may be assured of a friendly welcome from their English *confrères* whenever they visit Britain.

THE CURABILITY OF INSANITY.

Dr. Pliny Earle read an interesting paper on this question before the Association of Medical Superintendents of American Institutions for the Insane, on retiring from office as its President at Saratoga, N.Y., last summer. He returns to a subject which he has made his own by the large amount of labour he has expended upon it. His views, so far as they have hitherto been expressed, are so well-known in this country that it is unnecessary to repeat them. The present paper shows the actual results of treatment in a number of institutions, American and otherwise, brought down to a later date than that of former essays.

First, as to British asylums; a table is given of 23 asylums, the recoveries being arranged in accordance with the well-known table showing the duration of the attack and the recoveries, the results being as follows:—

1st class (first attack, less than three months' duration); the admissions were 8,316; recoveries, 4,051; per cent. of recoveries, 48·71. 2nd class (first attack, 3 to 12 months' duration); admissions, 2,613; recoveries, 764; per cent. of recoveries, 29·24. 3rd class (not first attack, less than 12 months' duration); admissions, 4,768; recoveries, 2,640; per cent. of recoveries, 55·37. The union of the first two classes gives all cases of first attack, and of less duration than one year. Of these the admissions were 10,929, and the recoveries 4,815, or 44·06 per cent. The percentage of recoveries in the 3rd class is in accordance with Dr. Earle's experience, that recovery takes place in a less proportion of cases of first attack than in cases subsequent to the first. This was shown in the report of the Northampton Lunatic Hospital for 1880. By throwing together the three classes, containing, as these do, cases of less than a year's duration,

which, it must be borne in mind, constitute in the United States, *recent* cases, and correspond to the rough test of curability adopted at Bethlem Hospital, the following figures come out : Admissions, 15,697 ; recoveries, 7,455 ; or 47.49 per cent. ; being somewhat above the proportion reached at Bethlem Hospital. Dr Earle shows that at the York Retreat there has been a large diminution in the proportion of recoveries on admissions in recent years in all the three classes ; in fact, for every 100 of recoveries of the so-called recent cases which were obtained during the first quarter of the century, there are but 63.75 now. He indicates the great value of Dr. Chapman's laborious collection of statistics of asylums, which appeared in this Journal in July, 1884, in which, the results of treatment of nearly 70,000 cases yielded 46.52 per cent., which although a fair result as things go, is a depressing contrast to the old-fashioned statement that from 75 to 90 per cent. of recent cases can be cured.

Dr. Earle proceeds to give the results of 15 American asylums, in the reports of which the recoveries of cases of less than a year's duration are given. Dr. Earle finding that not one of these hospitals discharged even 47 per cent. of recoveries of recent cases, while the average of them was below 39 per cent., made out the relation between the total recoveries and the number of admissions of recent cases. It appears that the former is larger by 668 than the recoveries of recent cases, while the number of admissions of recent cases is 6,499 smaller than the whole number of admissions. "Yet, strange as it may appear, the total of recoveries is only 46.88 per cent. of the admissions of recent cases. . . . Thus, after aiding and assisting the recoveries of recent cases by a supplementary and complimentary gift of the certainly not despicable number of 668 cases, we have been unable to swell them even to 50 per cent. of the admissions of recent cases."

Further, in 39 American asylums, during a period of from three to six years each, the admissions amounted to 33,318 ; the recoveries to 9,713 ; the proportion of recoveries to the admissions being 29.15 per cent. The number of *recent* cases admitted was 17,923, the proportion of all recoveries to the admissions of recent cases being 54.19 per cent. This calculation is made merely to show that, even after the recoveries are worked upon little more than half the admissions, they do not amount to a very high figure.

We regret that we cannot give more of the detailed information supplied by the author of this interesting paper, but must content ourselves with the following summary :—

1. Cases of first attack ; duration less than three months.
 - a. Earle's 8,316 cases at 23 British asylums. Recoveries 48.71 per cent.
 - b. Chapman's 38,283 cases at 46 British asylums. Recoveries 48.72 per cent.
 2. Cases of first attack ; duration less than 12 months.
 - a. Earle's 10,929 cases at 23 British asylums. Recoveries 44.06 per cent.
 - b. Chapman's 50,409 cases at 46 British asylums. Recoveries 43.79 per cent.
 3. Not first attack ; duration less than 12 months.
 - a. Earle's 4,768 cases at 23 British asylums. Recoveries 55.37 per cent.
 - b. Chapman's 19,574 cases at 46 British asylums. Recoveries 53.61 per cent.
- (American institutions not included for want of the necessary discrimination in their tables.)
4. All cases of duration less than 12 months.
 - a. Earle's 15,697 cases at 23 British asylums. Recoveries 47.49 per cent.
 - b. Chapman's 69,983 cases at 46 British asylums. Recoveries 46.52 per cent.
 - c. Earle's 8,063 cases at 15 American institutions. Recoveries 38.59 per cent.
 5. All recoveries, calculated on all admissions.
 - a. Chapman's 93,443 cases at 46 British asylums. Recoveries 37.95 per cent.
 - b. Earle's 33,318 cases at 39 American institutions. Recoveries 29.15 per cent.
 - c. Earle's 23,052 cases, third period, at 20 American institutions. Recoveries 29.91 per cent.
 - d. Earle's 14,372 cases, in one year, at 58 American institutions. Recoveries 27.88 per cent.

One conclusion from these statistics is that the recoveries in British asylums exceed those in American institutions by between eight and nine per cent. Another is the confirmation of Dr. Earle's previous contention, that there are not so many recent cases cured as was formerly alleged; and, further, that unfortunately the percentage of recoveries of all cases diminishes. Dr. Earle attributes this diminution to the admission of a larger proportion of chronic cases and of those which show greater degeneration, as in general paralysis, and to the increasing custom of not reporting as recoveries mere restorations from drunkenness, or forced temporary suspensions from habitual intoxication. The adoption of a higher degree of improvement as the criterion of recovery is mentioned as a possible cause. It is also intimated as just within the limits of possibility that statistics now are prepared "more generally in the spirit of conscientious loyalty to scientific truth."

It should be stated that important improvements were made in the Massachusetts Tables in 1879, and in those of our Association in 1883. It is to be regretted that the former do not give a Table corresponding to our Table II or IIA; and still more regrettable that the American Association does not adopt a series of amended Tables. Why not?

GENERAL PARALYSIS OR BLOOD-POISONING?

An American actor, Mr. McCullough, died recently, insane, in Philadelphia. He had at one time been under the care of Dr. Charles H. Nichols, at the Bloomingdale Asylum, New York, at which time he presented a typical example of general paralysis. A Dr. Engel, who treated him in Philadelphia, diagnosed "blood-poisoning." He died; a post-mortem was made, and the physicians who made it reported that there was disease of the blood-vessels of the brain, due to blood-poisoning. However, seeing that the pia-mater was opaque over a large part of the convexity of the brain, and was adherent, especially in the fronto-parietal region, and that in attempting to strip off the pia-mater small fragments of the cortex came away, the autopsy entirely confirms the diagnosis of the case made at the Bloomingdale Asylum. That a patient with a brain in the condition which is thus described should have been treated in Philadelphia by electricity and massage, is not pleasant to read of. Dr. Spitzka, it appears, had seen McCullough act in New York some three years ago, and thought he was in the first stage of general paralysis at that time. Dr. Engel is stated in the papers to be an advertising doctor, who day after day announced the case to the world, and gave out that McCullough would be cured. We can hardly suppose his reputation will be increased by the result, and the post-mortem revelation.

Correspondence.

STATISTICAL TABLES. TABLE V.

TO THE EDITORS OF *the Journal of Mental Science*.

GENTLEMEN,—It is now some years since the "British Medical Journal," in commenting upon the Annual Reports of our asylums for the insane, took occasion to refer to the stated causes of death among patients therein given as being, in many instances, loose and unsatisfactory, and urged the necessity for greater care and precision in this direction on the part of asylum physicians. That such criticism was at the time justified can admit of no doubt. Would it equally apply now?

I am aware, of course, that within a recent period the scope of this Table V. has been extended, and its statistical value, in the general opinion, increased in

consequence. That, however, is outside my present inquiry, which has reference solely to the causes of death as tabulated. Now, having paid some attention to the point, I am glad to think that improvement *has* taken place of late years in the records of the causes of death, and that, speaking generally, the instances open to objection are fewer than was formerly the case. Nevertheless there remains, I venture to think, room for further improvement, which a little additional care on the part of those primarily concerned would effectually secure; and I ask leave to endeavour in a few words to make good this contention.

Looking over Table V. in the various reports for 1884, several "causes" are to be found which, impartially considered, will probably be regarded as seriously defective. The list might be extended, but let a few examples, quoted *verbatim*, suffice:—"Paralysis. Dementia. Epilepsy with paralysis. Paralysis with convulsions. Exhaustion. Hemiplegia. Strangulation. Suffocation. Disease of brain. Inflammation and other diseases of brain softening. Brain disease. Brain disease with an accumulation of hair in the stomach."

I feel it to be quite needless for me to occupy your space in discussing in detail the individual defects of such returns: in the judgment of most of us the examples adduced will, it is believed, be held to justify my contention that there is still "room for improvement" in this direction.

In a somewhat different category, but nevertheless constituting a feature of Table V., against which I desire to contend, are what I may term the "exhaustions," and they are indeed legion. Let me say that, under certain circumstances, I would accept "exhaustion" as probably appropriate; for instance, in "exhaustion after amputation of the leg," which occurs in one report. Let me admit further that, from time to time, a case may occur in which the expression *faûte de mieux* may really seem to be unavoidable. If it were thus restricted it would not call for animadversion; but it does appear to me that the introduction of the expression in association with all sorts and conditions of affections which are specified, and of which, of course, exhaustion is merely the outcome, is unscientific, unnecessary, and therefore to be deprecated.

I look in the "nomenclature" of the College of Physicians, and there find that the term exhaustion occurs but twice—in one instance as exhaustion of muscles, and once in connection with "general injuries." Again, I examine the causes of death tables in the Registrar-General's Report, but nowhere in these do I find exhaustion mentioned.

From the fact that the expression occurs with more or less frequency in the majority (as I believe) of the reports, it must, I fear, be concluded that there is a large and influential section to whom the matter has not presented itself as it does to me. Nevertheless, the entire exclusion of "exhaustion" from some reports shows that I do not stand alone in my opinion as now expressed; and I am not without hope that a consideration of the point by those who have heretofore favoured "exhaustion," may lead some of them at least to accept the view that it may with propriety be omitted from their future statements. And I can imagine nothing so likely to convert them to this opinion as the study of a single year's collection of "exhaustions" in the various curious combinations which occur.

Perhaps some may say with regard to this "exhaustion" question—Why make so much of a very small matter? Very well: I will ask them to concede the "small matter" in deference to the views of others who think it, on the contrary, not without importance in the interests of greater accuracy.

I am, Gentlemen,

Your obedient Servant,
AMICUS.

November 14th, 1885.

Obituary.

DR. W. G. METCALF.

We were not able to record in our last number the melancholy death of Dr. Metcalf, of the Kingston Asylum, Ontario, which occurred on the 16th of August last. We now proceed to give some particulars of the tragedy. No words can adequately express our regret for the sad event and our sympathy with the survivors who mourn his loss at the early age of 38. We can speak from personal knowledge of the satisfactory condition of the asylum of which he was superintendent, and where he was beloved by his colleagues and by the patients to whose interests he devoted himself.

It appears that on the 13th of August Dr. Metcalf and Dr. Clarke, the Assistant Medical Officer, were making their usual morning visit. They had just entered the new separate building, which has already been described in this Journal,* when a male patient named Maloney, who stood in the corridor, suddenly turned round and assaulted Dr. Metcalf. He had possessed himself of a knife,† and stabbed his victim in the abdomen. When removed from the ward, Dr. Metcalf was found to be suffering from a wound in the back of the thigh and another, two or three inches long, across the abdomen, from which the intestines protruded, but were not wounded. Peritonitis, however, supervened, and Dr. Metcalf died from this cause and from shock on the 16th August, 1885.

The patient Maloney had been sent to the asylum in September, 1884, having previously been in gaol as an incendiary. When awaiting his trial he is said to have acted very strangely, refusing to eat and suspecting poison. A Board of Examination, consisting of the gaol surgeon, Dr. Oliver, Dr. Sullivan, and a judge, gave their opinion in a report, Dr. Sullivan pronouncing the prisoner perfectly sane, while Dr. Oliver held that he was insane and dangerous, while the judge certified that he was weak in body and mind and unfit to take care of himself. He was not, however, sent at first to an asylum, but remained for trial at the Assizes in September, 1884, where he was indicted, but was not tried for the offence, as the jury found him insane, upon which he was transferred to the Kingston Asylum. We observe that popular feeling, indignant in consequence of the cruel fate of Dr. Metcalf, clamoured for the execution of Maloney as a responsible criminal. We are assured, however, on the best authority, that he is unquestionably a lunatic.

The funeral of Dr. Metcalf took place at Uxbridge, and was largely attended, the pall-bearers being Dr. Workman, of Toronto; Dr. Daniel Clark, of the Toronto Asylum, and Drs. Bucke and Burgess, of the London Asylum, Ontario, where the deceased physician was formerly an assistant medical officer; Dr. Covert, of Toronto; Professor Osler, of Philadelphia; and Dr. O'Reilly, Inspector of Asylums.

Dr. Clarke, Dr. Metcalf's brother-in-law, has been promoted from the post of Assistant to that of Medical Superintendent. The Board of Management, while deploring the loss they have sustained, may congratulate themselves on having secured the services of so efficient and kind-hearted a successor. He is the son of the Hon. Charles Clarke, the Speaker of the Ontario Legislature.

PROSPER LUCAS, M.D.

The well-known author of the classical work on Heredity, entitled "*Traité philosophique et physiologique de l'hérédité naturelle dans les états de santé et de maladie du système nerveux*," died recently, at the age of 77, at Menecy (Seine-et-Oise). M. Lucas was formerly physician at the Bicêtre and the Asylum of Sainte Anne, where we had the pleasure of meeting him in 1878.

* January, 1885.

† It is stated that the knife was an improvised one, the blade, which was three inches long, having been fixed into a handle.

He was born at Saint-Brieuc in 1808. He took an active part in the political events of 1848, and on two occasions was returned at the elections.

M. Lucas was not a voluminous writer, but he was also the author of a dissertation entitled, "*De l'imitation contagieuse, ou de la propagation sympathétique des névroses et des monomanies.*"

M. Lucas will be remembered, however, by his treatise on Heredity, which, at the time it was published, was far in advance of anything that had been written. It was stated in the obituary notice of him in the "*Temps*" that the author had collected together, in his attendance on the insane, numerous documents which he intended to utilize in a volume supplementary to his large work, in which he would have studied the laws which regulate the inheritance of mental affections.

DR. LUNIER.

During the Congress of Mental Medicine held at Antwerp in September last, the unexpected death of M. Lunier was announced by the President as having occurred in Paris on the 5th of that month. The intelligence was communicated by his fellow-editor of the "*Annales Médico-Psychologiques*," M. Foville, who delivered a feeling discourse over his tomb, in which he stated that M. Lunier had been for nearly 40 years attached to the public service of the insane, including the honourable office of Inspector-General of the "*services administratifs*" of the Minister of the Interior. M. Foville points out that, while his numerous scientific works procured for him well-merited renown among alienist physicians, his publications relative to the administration of asylums extended his reputation beyond the limits of France, and that in this twofold character he has been considered by the foreigner, since the death of Parchappe, as one of the most eminent authorities in the science of medical administration in regard to the insane. We learn from this discourse that M. Lunier was *interne* of the Paris hospitals, and spent several years at the Salpêtrière. After being at the private asylum at Ivry, founded by Esquirol, he became Medical Superintendent of the lunatic asylum at Niort in 1851. Subsequently he took charge of the asylum at Blois, where he introduced numerous improvements and organized a quarter for paying patients, which remains one of the best in France. Appointed inspector in 1864, he contributed largely to the construction of asylums in the provinces. During the siege of Paris, when his duties as inspector were paralysed, he took an active part in assisting the "*Ambulances of the Press*," and he received the Cross of Officer of the Legion of Honour in acknowledgment of his indefatigable energy. During the International Congress of Mental Medicine in Paris, 1878, we received from him the "*Rapport à M. le Ministre de l'Intérieur sur le service des aliénés en 1874*," prepared by himself in conjunction with two *collaborateurs*, and found it to contain an able sketch of the past history of insane administration in France. At the Congress he was, perhaps, the most intelligent speaker in the discussion on the French law of lunacy, and consistently with this he took a leading part in the recent revision of the law of 1838 relative to the insane, personally assisting the Minister of the Interior, M. Fallières, in the preparation of the *projet de loi*, which has been for some time under the consideration of Parliament. Interested in questions bearing on the practice of medicine and the interests of the medical profession, M. Lunier was a member of the General Association of French Physicians from its foundation, and was one of the most useful members of the Council. He was also for long the treasurer of the French Psychological Association.

We must not omit to mention that M. Lunier was specially interested in the *Société de Tempérance*. In the name of this Association M. Motet pronounced a discourse at the tomb in his customary glowing language:—"Cruel death, by a blow as brutal as it was unforeseen, breaks our union, the closeness of which I measure by the grief which affects me. Let your friendship for me excuse my reference to it. All who have enjoyed the society of Lunier will

understand the supreme satisfaction with which I am permitted to recall it." M. Motet states that M. Lunier entertained the idea of gathering around him those who were appalled by the advancing wave of alcoholism, thinking it possible that, if this evil could not be arrested, its ravages might be lessened. Hence, with an energy which never flagged for a moment, he founded the Temperance Society, the utility of which soon became everywhere recognised. He was the General Secretary from its commencement, and, preaching by example, he began and completed researches in regard to the consumption of alcohol and its relation to intemperance, insanity, and crime. M. Motet says he was the soul, the life, of the 2,000 members who constituted this Society. An apostle, he desired to carry everywhere the good news to other countries, always sustained by a zeal into which there entered, in the words of M. Dumas, "*Autant de patriotisme pratique que d'amour de l'humanité.*"

M. Lunier became a member of the Academy of Medicine in May, 1883—an honour which M. Ritti, who spoke at the tomb in the name of the Société Médico-Psychologique, observed that he specially coveted. He adds that "the hour of triumph was not for him the commencement of repose. Work was his life, and, thanks to his prodigious activity, he succeeded in accomplishing numerous works; but he consecrated most of his time to objects of benevolence, goodfellowship, and the honour of the Association, thus proving that with him social duty was not an empty expression."

We conclude this notice in the words of M. Vallin, who represented the Academy of Medicine—words which will be recognised as appropriate by those who were personally acquainted with M. Lunier:—"Qui de nous en le voyant passer, il y a quelques jours, avec sa robuste apparence, avec sa belle et aimable figure, à laquelle une abondante chevelure blanche donnait non moins de dignité que de douceur, qui de nous eût pu songer un instant à une fin si prochaine? . . . Cher collègue, la mort est venue vous surprendre au milieu de tant d'activité, et c'est avant d'avoir achevé votre tâche que vous entrez dans l'éternel repos, mais vous vivrez dans le souvenir de tous ceux à qui vous avez fait du bien, de ceux que vous avez aimés, dans le souvenir aussi de ceux dont vous avez été trop peu de temps le collègue."

Appointments.

ALDOUS, G. F., F.R.C.P., M.R.C.S., Lond., appointed Res. Med. Officer to the County Asylum, Colney Hatch.

CALDECOTT, CHAS., M.R.C.S., L.S.A. Lond., appointed Res. Med. Officer to the Eastern Counties Asylum for Idiots, Colchester.

CLEMENT, R. J., L.R.C.P., L.R.C.S. Ed., appointed Res. Clin. Assistant at St. Luke's Hospital.

JOHNSTONE, J. CARLYLE, M.B., Senior 'Ass. Phys. Royal Edinb. Asylum, appointed interim Med. Superintendent of the Roxburgh, Berwick, and Selkirk District Asylum at Melrose.

MILLER, RICHARD, M.B., B. Ch. T.C.D., appointed Junior Assistant Medical Officer to the Sussex County Asylum, Haywards Heath.

MURDOCH, JAMES W. A., M.B., C.M. Glasg., appointed Assistant Medical Officer to the Berks County Lunatic Asylum.

STAPLE, JAS. D., L.S.A. Lond., appointed Res. Clin. Assistant at St. Luke's Hospital.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

EXAMINATIONS FOR THE CERTIFICATE IN PSYCHOLOGICAL MEDICINE

Will be held as follows, viz.:—For England, on

MONDAY AND TUESDAY, 29TH AND 30TH MARCH, 1886; MONDAY AND TUESDAY, 30TH NOVEMBER AND DECEMBER 1ST, 1886,

AT BETHLEM HOSPITAL, LONDON.

For Scotland, in JULY (date unfixed), 1886, and 11TH DECEMBER, 1886, at THE ROYAL EDINBURGH ASYLUM.

For Ireland, on FRIDAY, JANUARY 22, 1886, at DUBLIN.

Candidates intending to present themselves for examination must give notice thereof Fourteen Days prior to the Examination—

In England, to Dr. RAYNER, Hanwell.

In Scotland, to Dr. RUTHERFORD, Dumfries.

In Ireland, to Dr. COURTENAY, Limerick.

The following are the conditions and regulations respecting the Examinations:—

I. Candidates must be at least 25 years of age.

II. They must produce a Certificate of having resided in an asylum (affording sufficient opportunity for the study of mental disorders) as Clinical Clerk or Assistant Medical Officer for at least three months, or of having attended a course of Lectures on Insanity and the practice of an asylum (where there is clinical teaching) for a like period.

III. They must be Registered under the Medical Act (1858).

IV. The Examination to be held twice a year, at such times as shall be most convenient, in London, Scotland, and Ireland.

V. The Examination to be written and oral, including the actual examination of insane patients.

VI. The fee for the Examination to be fixed at £5 5s., to be paid to the Treasurer, for any expenditure incurred, including the Examiners' Fees.

VII. Candidates failing in the Examination to be allowed to present themselves again at the next and subsequent Examinations on payment of a fee of £3 3s.

VIII. The Certificate awarded to the successful candidates to be entitled "Certificate in Psychological Medicine of the Medico-Psychological Association of Great Britain and Ireland."

IX. Candidates intending to present themselves for Examination to give Fourteen Days' Notice in writing to either the General Secretary of the Association, the Secretary for Scotland, or the Secretary for Ireland, according as they desire to be examined in London, Edinburgh, or Dublin.

X. The Examiners shall be two in number for England and Wales, for Scotland, and for Ireland.

XI. They shall be appointed annually by the Council of the Association from Members of the Association. They shall not hold office for more than two years in succession.

XII. Form of Certificate to which the Seal of the Association is to be affixed:

THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

Examination for the Certificate in Psychological Medicine.

This is to certify that Mr. ——— has satisfied the Examiners as to his knowledge of the subjects of the Examination.

Dated

Hon. Secretary.

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